ARTICLE 20:06

INSURANCE

Chapter

20:06:14	Health and life insurance solicitation, Repealed.
20:06:15	Countersignature fees -- Title insurance, Repealed.
20:06:16	Premium tax.
20:06:17	Generic naming of life insurance, Repealed.
20:06:18	Producer licensing.
20:06:19	Exchange-traded call and put options.
20:06:20	Interest rate futures.
20:06:21	Long-term care insurance.
20:06:22	Loss ratios for health insurance policies.
20:06:23	Financial condition of insurers.
20:06:24	Life reinsurance, Repealed.
20:06:25	Annual financial filing requirements.
20:06:26	Rating and valuation of investments.
20:06:27	Standardized health care forms.
20:06:28	Form filing requirements.
20:06:29	Cancellations and replacements.

20:06:30	Life and health reinsurance.
20:06:31	Credit for reinsurance.
20:06:32	Declaratory rulings.
20:06:33	Utilization review organizations and managed care entities.
20:06:34	Grievance procedures.
20:06:35	Maternity coverage.
20:06:36	Risk-based capital (RBC) reports.
20:06:37	Actuarial opinions and memorandums.
20:06:38	Life insurance illustrations.
20:06:39	Individual plans.
20:06:40	Employer plans.
20:06:41	HIPAA rules -- Small employer.
20:06:42	Associations eligible for group health insurance.
20:06:43	Annuity mortality tables.
20:06:44	Insurance fraud prevention unit.
20:06:45	Privacy of consumer financial and health information.

20:06:46 HIPAA rules -- Nondiscrimination in the group market.

20:06:47 Group disability benefits.

20:06:48 Health insurance risk pool.

20:06:49 Discount plans.

20:06:50 Coordination of benefits.

20:06:51 Mortality tables for use in determining minimum reserve liabilities.

20:06:52 Discretionary clauses.

20:06:53 External and internal review.

20:06:54 Preventive services.

20:06:55 ~~Patient Protection and Affordable Care Act~~ Market regulations.

20:06:56 Minimum benefit standards.

CHAPTER 20:06:18

PRODUCER LICENSING

Section

20:06:18:22 Prohibited compensation arrangements.

Appendix A Midwest Zone Declaration Regarding Continuing Education Course Approval, Including Midwest Zone Standard Continuing Education Filing Form, repealed, 31 SDR 67, effective November 14, 2004.

Appendix B Application for Course Approval and Instructor Qualification Form, repealed, 31 SDR 67, effective November 14, 2004.

20:06:18:22. Prohibited compensation arrangements. Each health insurance issuer must provide equal compensation to an insurance producer for the sale of a similar health benefit plan sold inside and outside of an Exchange. No health insurance issuer may, directly or indirectly, enter into any contract, agreement, or arrangement with an insurance producer which provides for or results in the reduction and compensation paid to an insurance producer for the sale of a health benefit plan because the insured qualifies for coverage pursuant to SDCL 58-17-85. A health insurance issuer may pay a commission that does not vary based upon health status. A health insurance issuer may reimburse a producer for an insured who qualifies for coverage pursuant to SDCL 58-17-85 on a basis that varies the commission or that is based only upon the premium of a lesser rated risk only if the aggregate compensation the producer receives is not less than the compensation the health insurance issuer would pay for a similarly situated individual who qualifies for a lower rate. This section will apply to any policies or certificates issued after December 31, 2013.

Source:

General Authority: SDCL 58-17-87(8), 58-18- 79, 58-30-195 (10), 58-18B-36(10).

Law Implemented: SDCL 58-17-87(8), 58-18-80, 58-30-175.

CHAPTER 20:06:22

LOSS RATIOS FOR HEALTH INSURANCE POLICIES

Section

20:02:22:11	~~Levels of aggregation for medical loss ratio rebate calculations.~~ Repealed.
20:06:22:12	~~Frequency and timing of medical loss ratio rebate calculations and rebate payments.~~ Repealed.
20:06:22:13	~~Credibility adjustments to medical loss ratio.~~ Repealed.
20:06:22:14	~~Medical loss ratio rebate calculation for plan year 2011.~~ Repealed.
20:06:22:15	~~Single employer multi-state blended rates for plan year 2011.~~ Repealed.
20:06:22:16	~~Dual option coverage for single employers at blended rate for plan year 2011.~~ Repealed.
20:06:22:17	~~Loss ratio formula calculations for plan year 2011.~~ Repealed.
20:06:22:18	~~Medical loss ratio rebate calculation for plan year 2012.~~ Repealed.
20:06:22:19	~~Single employer multi-state blended rates for plan year 2012.~~ Repealed.
20:06:22:20	~~Dual option coverage for single employers at blended rate for plan year 2012.~~ Repealed.

20:06:22:21	~~Loss ratio formula calculations for plan year 2012.~~ Repealed.
20:06:22:22	~~Medical loss ratio rebate calculation for plan year 2013.~~ Repealed.
20:06:22:23	~~Single employer multi-state blended rates for plan year 2013.~~ Repealed.
20:06:22:24	~~Dual option coverage for single employers at blended rate for plan year 2013.~~ Repealed.
20:06:22:25	~~Loss ratio formula calculations for plan year 2013.~~ Repealed.
20:06:22:26	~~Credibility adjusted medical loss ratio for plan year 2013.~~ Repealed.
~~Appendix A~~	~~Formats For Reporting Rebate Calculations.~~ Repealed.
~~Appendix B~~	~~Credibility Tables.~~ Repealed.
~~Appendix C~~	~~Excerpts From The Supplemental Health Care Exhibit Instructions.~~ Repealed.
20:06:22:27	Rating band.
20:06:22:27.01.	Tobacco use defined.

20:06:22:28 Health status and gender factors precluded.

20:06:22:29 Rating area.

20:06:22:30 Rating variations.

20:06:22:31 Uniform age bands.

20:06:22:32 Single risk pool.

20:06:22:33 Index rate.

20:06:22:34 Permitted plan-level adjustments to the index rate.

20:06:22:35 Applicability.

~~**20:06:22:09. Definitions.** Terms used in §§ 20:06:22:09 to 20:06:22:26, inclusive, mean:~~

~~(1) "Affiliate," the statutory accounting definition for affiliate as contained in the then current NAIC Accounting Practice and Procedures Manual;~~

~~(2) "Blended rates," cross-subsidized rates charged for health insurance coverage provided by a single employer through two or more affiliates;~~

~~(3) "Business sold through an association," a policy issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations;~~

~~(4) "Calendar year," the period of time from January 1 of a given year to December 31 of that same year;~~

~~(5) "Claims unpaid," claims reported and in the process of adjustment, percentage withholds from payments made to contracted providers, incurred but not reported claims, and recoverables for anticipated coordination of benefits, and subrogation;~~

~~(6) "Clinical services," "incurred claims," as defined in subsection 19;~~

~~(7) "Contract reserves," reserves that are established which, due to the gross premium pricing structure at issue, account for the value of the future benefits at any time exceeding the value of any appropriate future valuation net premiums at that time. Contract reserves may not include premium deficiency reserves or reserves for expected medical loss ratio rebates;~~

~~(8) "Credibility adjustment," the adjustment to account for random statistical fluctuations in claims experience for smaller plans;~~

~~(9) "Direct paid claims," claim payments before ceded reinsurance and excluding assumed reinsurance except as follows. Paid claims for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct paid claims for the assuming entity's medical loss ratio rebate calculations and excluded from the ceding entity's medical loss ratio rebate calculations. If a block of business was subject to~~

~~indemnity reinsurance and administrative agreements, effective prior to the effective date of Patient Protection and Affordable Care Act (March 23, 2010), such that the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, then the assuming entity and not the ceding entity shall report the reinsured claims as part of its medical loss ratio rebate calculations. Claims payments recovered through fraud reduction efforts can be added back to claims in the medical loss ratio calculation, up to the amount of expenses expended to reduce fraud;~~

~~(10) "Dual contract," the case where a small or large group policyholder purchases in-network coverage from one issuer and out-of-network coverage from a different issuer that is an affiliate of the first issuer;~~

~~(11) "Dual option," the case where a small or large group policyholder purchases two or more different health plans from two or more affiliates;~~

~~(12) "Earned premiums," the statutory accounting definition for premium for health insurance coverage on a direct basis as contained in the then current NAIC Accounting Practices and Procedures Manual, plus or minus any portions of premium associated with group conversion privileges the issuer transfers between Group and Individual lines of business in its Annual Statement accounting, plus or minus an experience rating refunds paid or received, except as follows:~~

~~a) Experience rating refunds shall not include any rebates paid pursuant to §§ 20:06:22:14 to 20:06:22:17, inclusive, or §§ 20:06:22:18 to 20:06:22:21, inclusive, notwithstanding the definition in subsection 13;~~

b) Earned premium for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct earned premium for the assuming entity's medical loss ration rebate calculations and excluded from the ceding entity's medical loss ration rebate calculations; and

c) If a block of business was subject to indemnity reinsurance and administrative agreements effective prior to March 23, 2010, such that the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, then the assuming entity and not the ceding entity should report the reinsured earned premium as part of its medical loss ration rebate calculations;

(13) "Expenses to improve health care quality," those expenses as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010;

(14) "Experience rating refund," retrospective premium adjustments arising from retrospectively rated contracts as determined by the Statements of Statutory Accounting Principles 66, plus any incurred state premium refunds. If the 2012 experience is not fully credible, the experience rating refund for the plan year 2012 calculation shall also include any rebate paid pursuant to §§ 20:06:22:14 to 20:06:22:17, inclusive. The experience rating refund for the plan year 2013 calculation shall also include any rebates paid pursuant to §§ 20:06:22:14 to 20:06:22:17, inclusive, or §§ 20:06:22:18 to 20:06:22:21, inclusive.

~~(15) "Federal and State taxes and licensing or regulatory fees," those taxes and licensing or regulatory fees, as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit, as adopted by the National Association of Insurance Commissioners on August 17, 2010;~~

~~(16) "Fully credible," as it relates to experience, means experience generated by 75,000 or more life years;~~

~~(17) "Group conversion charges," means the portion of earned premium allocated to providing the privilege for a certificate holder terminated from a group health plan to purchase individual health insurance without providing evidence of insurability;~~

~~(18) "Health plan," health insurance coverage offered by a health insurance issuer as such terms are defined in the Public Health Service Act (including a grandfathered health plan) unless such coverage is an excepted benefit as provided for in the Public Health Service Act;~~

~~(19) "Incurred loss," incurred claims, as defined in subsection 20;~~

~~(20) "Incurred claims," claims for health insurance coverage on a direct basis incurred during the applicable plan year, plus unpaid claim reserves associated with claims incurred during the applicable plan year, plus the change in contract reserves, plus the claims-related portion of reserves for contingent benefits and lawsuits, plus any experience rating refunds paid or received, and reserves for experience rating refunds. This definition is consistent with the statutory accounting definition contained in the then current NAIC Accounting Practices and~~

~~Procedures Manual and the definition in Appendix C derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010. If there are any group conversion charges for a health plan, the conversion charges should be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount should be added to the incurred claims for the aggregation that provides coverage that is intended to be replaced by the conversion policies. Additionally, if the issuer transfers portions of earned premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, these amounts should be added to or subtracted from incurred claims;~~

~~(21) "Incurred medical pool incentives and bonuses," means arrangements with providers and other risk sharing arrangements as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010;~~

~~(22) "Individual health plan," a health plan offered to individuals in the individual market as such term is defined in the Public Health Service Act, but does not include short-term limited duration insurance as defined in the Public Health Service Act;~~

~~(23) "Large group health plan," a health plan offered in the large group market as such term is defined in the Public Health Service Act;~~

~~(24) "Life years," means the number of member months divided by 12;~~

~~(25) "Medical loss ratio rebate," the quantity specified in Section 2718(b)(1)(A) of the Public Health Service Act;~~

~~(26) "Minimum medical loss ratio standard," means the percentage determined in accordance with Section 2718(b)(1)(A)(i) or (ii) of the PHSA. In the case of minimum medical loss ratio standards that are not constant over an averaging period, the minimum standard will be the average of the standards used in each year weighted by earned premium less Federal and State taxes and licensing or regulatory fees;~~

~~(27) "Net healthcare receivables," means the healthcare receivable assets as defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on August 17, 2010;~~

~~(28) "Non-credible," as it relates to experience, means experience generated by less than 1,000 life years;~~

~~(29) "PHSA," means Public Health Service Act;~~

~~(30) "PPACA," means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152);~~

~~(31) "Partially credible," as it relates to experience, means experience generated by at least 1,000 life years but less than 75,000 life years;~~

~~(32) "Plan year," "calendar year," as defined in subsection 4;~~

~~(33) "Policyholder," means any entity that has entered into a contract with a health insurance issuer to receive health insurance coverage as defined in Section 2791(b) of the PHSA;~~

~~(34) "Reserves for experience rating refunds," means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement or due but unpaid for a state premium refund;~~

~~(35) "Situs of the contract," the jurisdiction in which the contract is issued or delivered as stated in the contract;~~

~~(36) "State premium refund," any rebate or refund of premium payable under state law as a result of state loss ratio requirements which need not be identical to the federal requirements in such matters as minimum percentage, definition of claim, definition of premium, aggregation, timing of calculations, etc;~~

~~(37) "Unearned premium reserves," reserves that are established to account for that portion of the premium paid in the plan year that is intended to provide coverage during a period which extends beyond the plan year;~~

~~(38) "Unpaid Claim Reserves," reserves and liabilities established to account for claims unpaid.~~

~~All terms defined in this section, shall be construed, and all calculations provided for by §§ 20:06:22:09 to 20:06:22:26 shall be performed, as to exclude the financial impact of any of the rebates. Not withstanding the foregoing, rebates shall be reflected as specifically provided for~~

~~in the instructions in Appendix A for Line 7 of the Rebate Calculation Supplemental Form.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:10. Applicability.** The provisions of §§ 20:06:22:09 to 20:06:22:26, inclusive, concerning the calculation and payment of medical loss ratio rebates applies to any health insurance issuer offering group or individual health insurance coverage including a grandfathered health plan as provided for in Section 2718 of the PHSA for plan years 2011, 2012, and 2013.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:11. Levels of aggregation for medical loss ratio rebate calculations.** Medical loss ratios shall be calculated at the licensed entity level within a state, with experience allocated~~

~~to states based on the situs of the contract. However, for individual business sold through an association, the allocation shall be based on the issue state of the certificate of coverage and for employer business issued through a group trust, the allocation shall be based on the location of the employer. Experience shall be further subdivided into individual health plans, small group health plans, and large group health plans.~~

~~Pursuant to Section 1312(c)(3) of PPACA, a state may require the individual and small group insurance markets within a state to be merged if the State determines appropriate. In this case, rebates shall be calculated at the licensed entity level within a state, further subdivided into individual and small group health plans, large group health plans. Plans classified as dual contract may be aggregated as follows. Experience may be treated as if it were all generated by the plan provided by the in-network issuer. An issuer that chooses this method of aggregation shall apply it for a minimum of three plan years. For purposes of this subsection, "experience," means all of the elements used to calculate the numerator and denominator.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:12. Frequency and timing of medical loss ratio rebate calculations and rebate payments.** Medical loss ratios shall be calculated annually by all health insurance issuers~~

~~that provide coverage through one or more health plans that are subject to §§ 20:06:22:09 to 20:06:22:27, inclusive. Medical loss ratios shall be calculated using data as of December 31 of the plan year except for incurred claims which shall be restated as of March 31 of the year following the plan year.~~

~~Medical loss ratios shall be reported to any applicable state by May 31 of the year following the plan year using the appropriate reporting format in Appendix A. Rebates shall be paid annually by June 30 of the year following the plan year.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:13. Credibility adjustments to medical loss ratio.** For plan year 2011 credibility adjustments are as follows:~~

~~(1) A credibility adjustment is not applicable to any aggregation as defined in § 20:06:22:11 that is either non-credible or fully credible based on plan year 2011 life years;~~

~~(2) The credibility adjustment for any aggregation as defined in § 20:06:22:11 that is partially credible based on plan year 2011 life years is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B;~~

(a) The Table 1 factor is determined using plan year 2011 life years for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories;

(b) The Table 2 factor may be determined using the plan year 2011 average plan deductible, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

For plan year 2012 credibility adjustments are as follows:

(1) A credibility adjustment is not applicable to any aggregation as defined in § 20:06:22:11 that is fully credible based on plan year 2012 life years or based on the sum of life years for plan years 2011 and 2012;

(2) If the sum of life years for plan years 2011 and 2012 is non-credible for any aggregation as defined in § 20:06:22:11, a credibility adjustment is not applicable;

(3) The credibility adjustment for any aggregation as defined in § 20:06:22:11 that is partially credible based on the sum of life years for plan years 2011 and 2012 is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B;

~~(a) The Table 1 factor is determined using the sum of plan year 2011 and plan year 2012 life years for the aggregation. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories;~~

~~(b) The Table 2 factor may be determined using the average plan deductible for plan year 2011 and plan year 2012 combined, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.~~

~~For plan year 2013 credibility adjustments are as follows:~~

~~(1) A credibility adjustment is not applicable to any aggregation as defined in § 20:06:22:11 that is either fully credible or non-credible based on the sum of life years for plan years 2011, 2012, and 2013;~~

~~(2) The credibility adjustment for any aggregation as defined in § 20:06:22:11 that is partially credible based on the sum of life years for plan years 2011, 2012, and 2013 is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B.~~

~~(a) The Table 1 factor is determined using the sum of life years for plan years 2011, 2012, and 2013 for the aggregation. The Table 1 factor for a value that is between two life year~~

~~categories is calculated by linearly interpolating the value between the lower and upper life year categories;~~

~~(b) The Table 2 factor may be determined using the average plan deductible for plan year 2011, plan year 2012, and plan year 2013 combined, weighted by life years, for the aggregation. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:14. Medical loss ratio rebate calculation for plan year 2011.** A rebate is not payable for any aggregation that is non-credible based on plan year 2011 life years. If, for any level of aggregation as defined in § 20:06:22:11, 50 percent or more of the total earned premium for 2011 is attributable to policies newly issued in 2011 with less than 12 months of experience in 2011, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2011. The excluded experience shall be added to the experience used to calculate the medical loss ratio for plan year 2012. For purposes of this section, the term, experience, means all of the elements used to calculate the numerator and denominator.~~

~~The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality. Incurred claims are those with incurral dates from January 1, 2011, to December 31, 2011, less any claims incurred in 2011 that are to be deferred to the plan year 2012 calculation. Expenses to improve health care quality are for the period from January 1, 2011, to December 31, 2011, less any expenses to improve health care quality from the 2011 plan year that are to be deferred to the plan year 2012 calculation.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:15. Single employer multi-state blended rates for plan year 2011.** For plan year 2011 an issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.~~

~~(1) The decision whether to apply the adjustment shall be made prior to January 1, 2011, and shall apply to all groups as described in §§ 20:06:22:15 to 20:06:22:17, inclusive;~~

~~(2) The adjustment shall be an objective formula that is defined prior to January 1, 2011;~~

(3) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate;

(4) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

Source: 37 SDR 131, effective January 11, 2011.

General Authority: SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.

Law Implemented: SDCL 58-17-4.2, 58-17-87.

20:06:22:16. Dual option coverage for single employers at blended rate for plan year 2011. For plan year 2011 an issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole.

(1) The decision whether to apply the adjustment shall be made prior to January 1, 2011, and shall apply to all groups as described in §§ 20:06:22:15 to 20:06:22:17, inclusive;

(2) The adjustment shall be an objective formula that is defined prior to January 1, 2011;

(3) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate;

(4) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.

Source: 37 SDR 131, effective January 11, 2011.

General Authority: SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.

Law Implemented: SDCL 58-17-4.2, 58-17-64.

20:06:22:17. Loss ratio formula calculations for plan year 2011. For the 2011 plan year the denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less federal and state taxes and licensing or regulatory fees. Earned premiums are for the period from January 1, 2011, to December 31, 2011, less any premiums earned in the 2011 plan year that are to be deferred to the plan year 2012 calculation. Federal and state taxes and licensing or regulatory fees are for the period from January 1, 2011, to December 31, 2011, less any federal and state taxes and licensing fees from the 2011 plan year that are to be deferred to the plan year 2012 calculation.

The medical loss ratio is calculated as the unrounded ratio of the numerator, adjusted for conditions in §§ 20:06:22:15 and 20:06:22:16, to the denominator as used in this section. The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in this section plus any applicable credibility adjustment. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group, or large group). If the result is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less

~~federal and state taxes and licensing or regulatory fees for 2011. The resulting amount is the rebate to be paid. If the result is zero or less, no rebate is paid.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:18. Medical loss ratio rebate calculation for plan year 2012.** A rebate is not payable for any aggregation that is non-credible based on the sum of life years for plan years 2011 and 2012.~~

~~If, for any level of aggregation as defined in § 20:06:22:11, 50 percent or more of the total earned premium for 2012 is attributable to policies newly issued in 2012 with less than 12 months of experience in 2012, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2012. The excluded experience shall be added to the experience used to calculate the medical loss ratio for plan year 2013. For purposes of this section, the term, experience, means all of the elements used to calculate the numerator and denominator.~~

~~For plan year 2012 the numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality. Incurred claims~~

~~are those with incurral dates from January 1, 2012, to December 31, 2012, plus any incurred claims deferred from the plan year 2011 calculation, less any claims incurred in 2012 that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, incurred claims are those with incurral dates from January 1, 2011, to December 31, 2012, less any claims incurred in 2012 that are to be deferred to the plan year 2013 calculation.~~

~~For plan year 2012, expenses to improve health care quality are those expenses for the period from January 1, 2012, to December 31, 2012, plus any expenses to improve health care quality deferred from the plan year 2011 calculation, less any expenses to improve health care quality from the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, expenses to improve health care quality are those for the period from January 1, 2011, to December 31, 2012, less any expenses to improve health care quality from the 2012 plan year that are to be deferred to the plan year 2013 calculation.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:19. Single employer multi-state blended rates for plan year 2012.** For plan year 2012, an issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole as follows:~~

~~(1) The decision whether to apply the adjustment shall be made prior to January 1, 2012, and shall apply to all groups as described in this section;~~

~~(2) The adjustment shall be an objective formula that is defined prior to January 1, 2012;~~

~~(3) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate;~~

~~(4) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:20. Dual option coverage for single employers at blended rate for plan year 2012.** For plan year 2012, an issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole as follows:~~

~~(1) The decision whether to apply the adjustment shall be made prior to January 1, 2012, and shall apply to all groups as described in § 20:06:22:19;~~

~~(2) The adjustment shall be an objective formula that is defined prior to January 1, 2012;~~

~~(3) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for the employer group in aggregate;~~

~~(4) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:21. Loss ratio formula calculations for plan year 2012.** For plan year 2012, the denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less federal and state taxes and licensing or regulatory fees. Earned premiums are for the period from January 1, 2012, to December 31, 2012, plus any earned premiums deferred from the plan year 2011 calculation, less any premiums earned in the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, earned premiums are for the period from January 1, 2011, to December 31, 2012, less any premiums earned in the 2012 plan year that are to be deferred to the plan year 2013 calculation.~~

~~Federal and state taxes and licensing or regulatory fees are for the period from January 1, 2012, to December 31, 2012, plus any federal and state taxes and licensing or regulatory fees deferred from the plan year 2011 calculation, less any federal and state taxes and licensing or regulatory fees from the 2012 plan year that are to be deferred to the plan year 2013 calculation. If the 2012 experience is not fully credible, federal and state taxes and licensing or regulatory fees are for the period from January 1, 2011, to December 31, 2012, less any federal and state taxes and licensing or regulatory fees from the 2012 plan year that are to be deferred to the plan year 2013 calculation.~~

~~The medical loss ratio is calculated as the unrounded ratio of the numerator as described in this section, adjusted for conditions in §§ 20:06:22:19 to 20:06:22:21, inclusive, to the denominator in this section.~~

~~The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in this section and any applicable credibility adjustment. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group, or large group). If the result is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less federal and state taxes and licensing or regulatory fees for the plan year. The resulting amount is the rebate to be paid. If the result is zero or less, no rebate is paid.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:22. Medical loss ratio rebate calculation for plan year 2013.** A rebate is not payable for any aggregation that is non-credible based on the sum of life years for plan year 2011, plan year 2012, and plan year 2013.~~

~~If, for any level of aggregation as defined in § 20:06:22:11, 50 percent or more of the total earned premium for 2013 is attributable to policies newly issued in 2013 with less than 12 months of experience in 2013, the experience of these policies may be excluded from the medical loss ratio calculation for plan year 2013. The excluded experience shall be added to the experience used to calculate the medical loss ratio for plan year 2014. For purposes of this section the term, experience, means all of the elements used to calculate the numerator and denominator.~~

~~The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality. Incurred claims are those with incurral dates from January 1, 2011, to December 31, 2013, less any claims incurred from January 1, 2013, to December 31, 2013, that are to be deferred to the plan year 2014 calculation. Expenses to improve health care quality are those expenses for the period from January 1, 2011, to December 31, 2013, less any expenses to improve quality from the 2013 plan year that are to be deferred to the plan year 2014 calculation.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-42, 58-17-64.~~

~~**20:06:22:23. Single employer multi-state blended rates for plan year 2013.** An issuer that provides insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole:~~

~~(1) The decision whether to apply the adjustment shall be made prior to January 1, 2013, and shall apply to all groups as described in this section;~~

~~(2) The adjustment shall be an objective formula that is defined prior to January 1, 2013;~~

~~(3) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate;~~

~~(4) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.~~ Repealed.

S**ource:** 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:24. Dual option coverage for single employers at blended rate for plan year 2013.** An issuer that provides dual option insurance coverage to a single employer at blended~~

~~rates may make an adjustment to each affiliate's numerator calculation to reflect the medical loss ratio calculated for the employer as a whole:~~

~~(1) The decision whether to apply the adjustment shall be made prior to January 1, 2013, and shall apply to all groups as described in § 20:06:22:23;~~

~~(2) The adjustment shall be an objective formula that is defined prior to January 1, 2013;~~

~~(3) For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the plan year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate;~~

~~(4) An issuer that chooses to use such an adjustment shall use it for a minimum of three plan years.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:25. Loss ratio formula calculations for plan year 2013.** For plan year 2013, the denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums less federal and state taxes and licensing or regulatory fees. Earned premiums are for the period from January 1, 2011, to December 31, 2013, less any premiums earned in 2013 that are to be deferred to the plan year 2014 calculation. Federal and state taxes and licensing or~~

~~regulatory fees are for the period from January 1, 2011, to December 31, 2013, less any federal and state taxes and licensing or regulatory fees from the 2013 plan year that are to be deferred to the plan year 2014 calculation. The medical loss ratio is calculated as the unrounded ratio of the numerator in § 20:06:22:22, adjusted for conditions in §§ 20:06:22:23 and 20:06:22:24, to the denominator in this section.~~

~~If both of the following conditions are met, no credibility adjustment is applicable:~~

~~(1)Each of plan years 2011, 2012, and 2013 are partially credible based on the life years for each plan year, respectively; and~~

~~(2) The medical loss ratio, before applying any credibility adjustments, for each of plan years 2011, 2012, and 2013 is less than the minimum medical loss ratio standard for each plan year, respectively.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~**20:06:22:26. Credibility adjusted medical loss ratio for plan year 2013.** The plan year 2011 medical loss ratio is the quantity calculated in § 20:06:22:17. The plan year 2012 medical loss ratio is calculated using the methodology given in § 20:06:22:21 with the exception that only experience from January 1, 2012, through December 31, 2012, is to enter into the calculation. The plan year 2013 medical loss ratio is the quantity calculated using the~~

~~methodology given in § 20:06:22:23 with the exception that only experience from January 1, 2013, through December 31, 2013, is to enter into the calculation.~~

~~The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in § 20:06:22:24 and any applicable credibility adjustment. The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard (individual, small group, or large group).~~

~~If the result of subtraction is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium less federal and state taxes and licensing or regulatory fees for the plan year. The resulting amount is the rebate to be paid. If the result of J is zero or less, no rebate is paid.~~ Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**General Authority:** SDCL 58-4-1, 58-17-4.2, 58-17-64, 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-4.2, 58-17-64.~~

~~DEPARTMENT OF REVENUE AND REGULATION~~

~~DIVISION OF INSURANCE~~

~~FORMATS FOR REPORTING REBATE CALCULATIONS~~

~~Chapter 20:06:22~~

~~APPENDIX A~~

~~SEE: §§ 20:06:22:09 and 20:06:22:12~~

Repealed.

Source: 37 SDR 131, effective January 11, 2011.

~~**Appendix A. Formats for Reporting Rebate Calculations**~~

~~This appendix contains formats to report rebate calculations for the 2011, 2012, and 2013 plan years. Each report will require a separate supplemental information form for each experience year in the calculation.~~

"Line of Business" is the applicable aggregation as defined in § 20:06:22:11.

"Minimum Medical Loss Ratio" is the loss ratio as defined in § 20:06:22:09.

REBATE CALCULATION

FORM FOR PLAN YEAR 2011

Company_____ NAIC Company Code_____

For the State of_____ NAIC Group Code_____

Line of Business_____ Minimum Medical Loss_____

Ratio_____

Address_____ Person Completing Exhibit_____

Title_____ Telephone Number_____

1	2	3
1.	Life Years	
2.	Earned Premium	
3.	Federal and State Taxes and Licensing or Regulatory Fees	
4.	Expenses to Improve Health Care Quality	
5.	Paid Claims	
6.	Unpaid Claim Reserve	
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds	
8.	Change in Contract Reserves	
9.	Contingent Benefit and Lawsuit Reserve	
10.	Incurred Medical Pool Incentives and Bonuses	
11.	Net Healthcare Receivables	
12.	Incurred Claims	
13.	Medical Loss Ratio	
14.	Credibility Adjustment Factor	
15.	Credibility Adjusted Medical Loss Ratio	
16.	Rebate	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____

Signature

_____

Name - Please Type

_____

Title - Please Type

_____

~~Date~~

INSTRUCTIONS

REBATE CALCULATION FORM FOR PLAN YEAR 2011

Line 1: Life Years

Rebate Supplemental Form for experience year 2011

Line 2: Earned Premiums

Rebate Supplemental Form for experience year 2011

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year 2011

Line 4: Expenses to Improve Health Care Quality

Rebate Supplemental Form for experience year 2011

Line 5: Paid Claims

~~Rebate Supplemental Form for experience year 2011~~

~~Line 6: Unpaid Claim Reserve~~

~~Rebate Supplemental Form for experience year 2011~~

~~Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds~~

~~Rebate Supplemental Form for experience year 2011~~

~~Line 8: Change in Contract Reserves~~

~~Rebate Supplemental Form for experience year 2011~~

~~Line 9: Contingent Benefit and Lawsuit Reserve~~

~~Rebate Supplemental Form for experience year 2011~~

~~Line 10: Incurred Medical Pool Incentives and Bonuses~~

~~Rebate Supplemental Form for experience year 2011~~

~~Line 11: Net Healthcare Receivables~~

~~Rebate Supplemental Form for experience year 2011~~

~~Line 12: Incurred Claims as of 3/31 = Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11~~

~~Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3)~~

~~Line 14: Credibility Adjustment based on the number of life years in Line 1 and the methodology in § 20:06:22:13~~

~~Line 15: Credibility Adjusted Medical Loss Ratio = Line 13 + Line 14~~

Line 16: ~~If 2011 experience is non-credible as determined by Line 1, Rebate = 0, else, If (Minimum Medical Loss Ratio – Line 15) is less than or equal to zero, Rebate = 0, else Rebate = (Minimum Medical Loss Ratio – Line 15) (Line 2 – Line 3),~~

~~where (Minimum Medical Loss Ratio – Line 15) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.~~

REBATE CALCULATION FORM

FOR PLAN YEAR 2012

Company_____ NAIC Company Code_____

For the State of_____ NAIC Group Code_____

Line of Business_____ Minimum Medical Loss_____

Address_____ Person Completing Exhibit_____

Title_____ Telephone Number_____

1	2	3	4	5
1.	Life Years			
2.	Earned Premium			
3.	Federal and State Taxes and Licensing or Regulatory Fees			
4.	Expenses to Improve Health Care Quality			
5.	Paid Claims			
6.	Unpaid Claim Reserve			
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds			

8.	Change in Contract Reserves			
9.	Contingent Benefit and Lawsuit Reserve			
10.	Incurred Medical Pool Incentives and Bonuses			
11.	Net Healthcare Receivables			
12.	Incurred Claims			
13.	Medical Loss Ratio	XXX		
14.	Credibility Adjustment Factor	XXX		
15.	Credibility Adjusted Medical Loss Ratio	XXX	XXX	
16.	Rebate	XXX	XXX	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____

Signature

_____

Name - Please Type

_____

Title - Please Type

_____

Date

INSTRUCTIONS

REBATE CALCULATION FORM FOR PLAN YEAR 2012

Line 1: Life Years

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 2: Earned Premiums

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)

Line 4: Expenses to Improve Health Care Quality

~~Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)~~

~~Line 5: Paid Claims~~

~~Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)~~

~~Line 6: Unpaid Claim Reserve~~

~~Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)~~

~~Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds~~

~~Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)~~

~~Line 8: Change in Contract Reserves~~

~~Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)~~

~~Line 9: Contingent Benefit and Lawsuit Reserve~~

~~Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)~~

~~Line 10: Incurred Medical Pool Incentives and Bonuses~~

~~Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)~~

~~Line 11: Net Healthcare Receivables~~

~~Rebate Supplemental Form for experience year (2011 in Column 3 and 2012 in Column 4)~~

~~Line 12: Incurred Claims as of 3/31 = Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11~~

~~Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3) for Column 4 and Column 5~~

~~Line 14: Credibility Adjustment based on the number of life years in Line 1 for Column 4 and Column 5 and the methodology in § 20:06:22:13.~~

~~Line 15: Column 5:~~

~~If Line 14 Column 4 is equal to zero~~

~~Credibility Adjusted Medical Loss Ratio = Line 13 Column 4~~

~~If Line 14 Column 4 is not equal to zero~~

~~Credibility Adjusted Medical Loss Ratio = Line 13 Column 5 + Line 14 Column 5~~

~~Line 16: If 2011 plus 2012 experience is non-credible as determined by Line 1, Column 5, Rebate = 0, else,~~

~~If (Minimum Medical Loss Ratio – Line 15) is less than or equal to zero, Rebate = 0, else,~~

~~Rebate = (Minimum Medical Loss Ratio – Line 15 Column 5) (Line 2 Column 4 – Line 3 Column 4), where (Minimum Medical Loss Ratio – Line 15 Column 5)~~

~~has been rounded to the nearer one tenth of one percentage point and Rebate is rounded to the nearer dollar.~~

REBATE CALCULATION FORM

FOR PLAN YEAR 2013

Company_____ NAIC Company Code_____

For the State of_____ NAIC Group Code_____

Line of Business_____ Minimum Medical Loss_____

Address_____ Person Completing Exhibit_____

Title_____ Telephone Number_____

1	2	3	4	5	6
1.	Life Years				
2.	Earned Premium				
3.	Federal and State Taxes and Licensing or Regulatory Fees				
4.	Expenses to Improve Health Care Quality				
5.	Paid Claims				
6.	Unpaid Claim Reserve				
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds				

8.	Change in Contract Reserves				
9.	Contingent Benefit and Lawsuit Reserve				
10.	Incurred Medical Pool Incentives and Bonuses				
11.	Net Healthcare Receivables				
12.	Incurred Claims				
13.	Medical Loss Ratio				
14.	Credibility Adjustment Factor	XXX	XXX	XXX	
15.	Credibility Adjusted Medical Loss Ratio	XXX	XXX	XXX	
16.	Rebate	XXX	XXX	XXX	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____

Signature

_____

Name - Please Type

_____

Title - Please Type

_____

Date

INSTRUCTIONS

REBATE CALCULATION FORM FOR PLAN YEAR 2013

Line 1: Life Years

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 2: Earned Premium

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 3: Federal and State Taxes and Licensing or Regulatory Fees

Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)

Line 4: Expenses to Improve Health Care Quality

~~Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)~~

~~Line 5: Paid Claims~~

~~Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)~~

~~Line 6: Unpaid Claim Reserve~~

~~Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)~~

~~Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds~~

~~Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)~~

~~Line 8: Change in Contract Reserves~~

~~Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)~~

~~Line 9: Contingent Benefit and Lawsuit Reserve~~

~~Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)~~

~~Line 10: Incurred Medical Pool Incentives and Bonuses~~

~~Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)~~

~~Line 11: Net Healthcare Receivables~~

~~Rebate Supplemental Form for experience year (2011 in Column 3, 2012 in Column 4 and 2013 in Column 5)~~

~~Line 12: Incurred Claims as of 3/31= Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11~~

~~Line 13: Medical Loss Ratio = (Line 4 + Line 12) / (Line 2 – Line 3).~~

~~Line 14: Credibility Adjustment based on the number of life years in Line 1 for Column 6 and the methodology in § 20:06:22:13.~~

~~Line 15: Credibility Adjustment Medical Loss Ratio = Line 13 + Line 14 for Column 6.~~

~~Line 16: If the sum of 2011, 2012 and 2013 experience is non-credible as determined by Line 1 Column 6, Rebate = 0, else,~~

~~If the experience of each of plan years 2011, 2012, and 2013 are partially credible as determined by Line 1 Columns 3, 4, and 5, respectively and the medical loss ratio for each of plan years 2011, 2012, and 2013 as determined by Line 13 Columns 3, 4, and 5, respectively, is less than the Minimum Loss Ratio for each plan year, respectively, Rebate = (Minimum Medical Loss Ratio – Line 13 Column 6) (Line 2 Column 5 – Line 3 Column 5) rounded to the nearer dollar, else,~~

~~If (Minimum Medical Loss Ratio – Line 15 Column 6) is less than or equal to zero, Rebate = 0, else~~

~~Rebate = (Minimum Medical Loss Ratio – Line 15 Column 6) – (Line 2 Column 5 – Line 3 Column 5), where (Minimum Medical Loss Ratio – Line 15 Column~~

6) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

REBATE CALCULATION SUPPLEMENTAL FORM

Plan Year_____

Experience Year_____

Company_____ NAIC Company Code_____

For the State of_____ NAIC Group Code_____

Line of Business_____

Address_____ Person Completing Exhibit_____

Title_____ Telephone Number_____

1	2	3	4	5	6
1.	Life Years				
2.	Earned Premium				
3.	Federal and State Taxes and Licensing or Regulatory Fees				
4.	Expenses to Improve Health Care Quality				
5.	Paid Claims				
6.	Unpaid Claim Reserve				
7.	Experience Rating Refunds and Reserves for Experience Rating Refunds				
8.	Change in Contract Reserves				
9.	Contingent Benefit and Lawsuit Reserve				
10.	Incurred Medical Pool Incentives and Bonuses				
11.	Net Healthcare Receivables				
12.	Incurred Claims				

INSTRUCTIONS

REBATE CALCULATION SUPPLEMENTAL FORM

Column 3 is data from the Supplemental Health Care Exhibit in the NAIC Annual Statement for the experience year.

Column 4 is data for policies newly issued in the experience year with less than 12 months of experience in that year that are excluded from the medical loss ratio calculation for the plan year of issue and will be added back in the next plan year.

Column 5 is data for policies newly issued in a prior experience year with less than 12 months of experience in that year that were excluded from the medical loss ratio calculation for a prior plan year and are added back in this plan year. See § 20:06:22:14, 20:06:22:18, or 20:06:22:22 for additional details.

Note that quantities in Lines 2 through 9 should be allocated to represent only the experience associated with the deferred business using reasonable methods.

~~Line 1: Life Years~~

~~Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1 Other Indicators, Column(s) for applicable line of business Line 4 divided by 12 and rounded to zero decimal places.~~

~~Line 2: Earned Premium~~

~~Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 2, Column(s) for applicable line of business Line 1.8 Line 1.7, plus Part 1, Column(s) for applicable line of business Line 1.2 + Line 1.3, plus or minus any portions of premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, plus or minus any incurred experience rating refunds.~~

~~Line 3: Federal and State Taxes and Licensing or Regulatory Fees~~

~~Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business Line 1.5 + Line 1.6 + Line 1.7~~

~~Line 4: Expenses to Improve Health Care Quality~~

~~Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 6.3~~

~~Line 5: Paid Claims~~

~~Amounts paid on claims incurred in the experience year as of March 31 of the year following the plan year, plus or minus any portions of premium associated with group conversion privileges between Group and Individual lines of business in its Annual Statement accounting, plus Deductible Fraud and Abuse Detection/Recovery Expenses from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 4, minus any state stop loss, market stabilization and claim/census based assessments from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 2.4, plus or minus any adjustment indicated in this chapter.~~

~~Line 6: Unpaid Claim Reserve~~

~~The reserve for amounts unpaid on claims incurred in the experience year as of March 31 of the year following the plan year.~~

~~Line 7: Experience Rating Refunds and Reserves for Experience Rating Refunds~~

~~Experience rating refunds incurred in the experience year and paid through March 31 of the year following the plan year, plus the estimate as of March 31 of the year following the plan year for any reserves experience rating refunds incurred in the experience year, plus any state premium refunds incurred in the experience year. For the 2012 plan year, include any rebate paid pursuant to §§ 20:06:22:14 to 20:06:22:17, inclusive, for plan year 2011 if the 2012 experience is not fully credible on its own and 2011 experience enters into the plan year 2012 calculation. For the 2013 plan year, include any rebate paid pursuant to §§ 20:06:22:14 to 20:06:22:17, inclusive, for plan year 2011, plus any rebate paid pursuant to § 20:06:22:18 for plan year 2012.~~

~~Line 8: Change in contract reserves~~

~~Change in contract reserves from December 31 of the year prior to the experience year to December 31 of the plan year after eliminating the effect of any valuation basis changes.~~

~~Line 9: Contingent Benefit and Lawsuit Reserve~~

~~Contingent Benefit and Lawsuit Reserve for claims incurred in the experience year as of March 31 of the year following the plan year.~~

~~Line 10: Incurred Medical Pool Incentives and Bonuses~~

~~Medical Pool Incentives and Bonuses incurred in the experience year as of March 31 of the year following the plan year.~~

~~Line 11: Net Healthcare Receivables~~

~~Net Healthcare Receivables incurred in the experience year as of March 31 of the year following the plan year.~~

~~Line 12. Line 5 + Line 6 + Line 7 + Line 8 + Line 9 + Line 10 – Line 11~~

~~DEPARTMENT OF REVENUE AND REGULATION~~

~~DIVISION OF INSURANCE~~

~~CREDIBILITY TABLES~~

~~Chapter 20:06:22~~

~~APPENDIX B~~

~~SEE: § 20:06:22:13~~

Repealed.

Source: 37 SDR 131, effective January 11, 2011

~~Appendix B. Credibility Tables~~

~~Table 1~~	~~–~~
~~Base Credibility Additive Adjustment Factors~~	~~–~~
~~Life Years~~	~~Additive Adjustment~~
~~≤ 1,000~~	~~No Credibility~~
~~1,000~~	~~8.3%~~
~~2,500~~	~~5.2%~~
~~5,000~~	~~3.7%~~
~~10,000~~	~~2.6%~~
~~25,000~~	~~1.6%~~
~~50,000~~	~~1.2%~~
~~75,000~~	~~0.0%~~

~~Table 2~~	~~–~~
~~Plan Cost-Sharing Adjustment Factors by~~	~~–~~
~~Deductible Range~~	~~Adjustment Factor~~
~~≤ $2,500~~	~~1.000~~
~~$2,500~~	~~1.164~~
~~$5,000~~	~~1.402~~
~~≥ − $10,000~~	~~1.736~~

~~DEPARTMENT OF REVENUE AND REGULATION~~

~~DIVISION OF INSURANCE~~

~~EXCERPTS FROM THE SUPPLEMENTAL HEALTH CARE EXHIBIT INSTRUCTIONS~~

~~Chapter 20:06:22~~

~~APPENDIX C~~

~~See: § 20:06:22:09(13)(15)(20)(21)(27)~~

Repealed.

Source: 37 SDR 131, effective January 11, 2011.

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

Federal and State Taxes and Licensing or Regulatory Fees:

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1:

Line 1.5 – Federal Taxes and Federal Assessments

Refer to SSAP 10R for "current income taxes incurred."

Include: All federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the Public Health Service Act.

Exclude: Federal income taxes on investment income and capital gains.

Line 1.6 – State Insurance, Premium and Other Taxes and Assessments

~~Include: Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State.~~

~~Guaranty fund assessments~~

~~Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by states.~~

~~Advertising required by law, regulation or ruling, except advertising associated with investments.~~

~~State income, excise, and business taxes other than premium taxes. State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes.~~

~~EITHER*:~~

a. Payments to a state, by not-for profit health plans, of premium tax exemption values in lieu of state premium taxes limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group;

b. Payments by not-for-profit health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and Large Group. These payments must be state-based requirements to qualify for inclusion in this line item;

OR

c. Payments made by (federal income) tax exempt health plans for community benefit expenditures** limited to the state premium tax rate applicable to for profit entities subject to premium tax multiplied by the allocated premiums earned for Individual, Small Group and

Large Group. (NOTE: If the instruction for Line 1.5 above excludes federal income taxes, then tax-exempt health plans may NOT include community benefit expenditures in this line.)

Exclude: State sales taxes, if company does not exercise option of including such taxes with the cost of goods and services purchased. Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes. Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

*These expenditures may not be double counted between this category; the federal or state assessments for similar purposes included in Lines 1.5, 1.6, or 2.4; or the Quality Improvement expenses reported in Line 6.1.

**Community benefit expenditures are for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes activities that:

- Are available broadly to the public and serve low-income consumers;

- Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);

- Address federal, state, or local public health priorities such as advancing health care knowledge through education or research that benefits the public;

- Leverage or enhance public health department activities such as childhood immunization efforts; or

- Otherwise would become the responsibility of government or another tax-exempt organization.

Line 1.7 – Regulatory Authority Licenses and Fees

Include: Statutory assessments to defray operating expenses of any state insurance department.

Examination fees in lieu of premium taxes as specified by state law.

Exclude: Fines and penalties of regulatory authorities.

Fees for examinations by state departments other than as referenced above.

Expenses to Improve Health Care Quality:

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3:

Improving Health Care Quality Expenses – General Definition:

Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve

~~quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:~~

- ~~Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;~~
- ~~Prevent hospital readmissions;~~
- ~~Improve patient safety and reduce medical errors, lower infection and mortality rates;~~
- ~~Increase wellness and promote health activities; or~~
- ~~Enhance the use of health care data to improve quality, transparency, and outcomes.~~

~~NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.~~

~~PARTS 3A AND 3B~~

~~COLUMNS:~~

~~Column 1 – Improve Health Outcomes~~

~~Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined above. This category can include costs for associated activities such as:~~

- ~~Effective case management, Care coordination, and Chronic Disease Management, including:~~

~~Patient centered intervention such as:~~

- ~~Making/verifying appointments,~~
- ~~Medication and care compliance initiatives,~~

- Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center),
- Programs to support shared decision making with patients, their families and the patient's representatives; and
- Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;

- Incorporating feedback from the insured to effectively monitor compliance;
- Providing coaching or other support to encourage compliance with evidence based medicine;
- Activities to identify and encourage evidence based medicine;
- Use of the medical homes model as defined for purposes of section 3602 of PPACA;
- Activities to prevent avoidable hospital admissions;
- Education and participation in self management programs;
- Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing

with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance; and

- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Columns 1-5;

- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

- Quality reporting and documentation of care in non-electronic format; and

- Health information technology expenses to support these activities (report in Column 5 – see instructions) including:

  - Data extraction, analysis and transmission in support of the activities described above; and

  - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; and

~~Column 2 – Activities to Prevent Hospital Readmission~~

~~Expenses for implementing activities to prevent hospital readmissions as defined above, including~~

- ~~Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;~~
- ~~Personalized post discharge counseling by an appropriate health care professional;~~
- ~~Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and~~
- ~~Health information technology expenses to support these activities (report in Column 5 – see instructions) including:~~
    - ~~Data extraction, analysis and transmission in support of the activities described above; and~~

- Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; and

Column 3 – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to avoid harm;
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and

- Health information technology expenses to support these activities (report in Column 5 – See instructions), including;

    - Data extraction, analysis and transmission in support of the activities described above; and

    - Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; or

Column 4 – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;

- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

- ~~Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;~~

- ~~Public health education campaigns that are performed in conjunction with state or local health departments;~~

- ~~Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:~~

    - ~~Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit;~~

- ~~Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;~~

- ~~Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and~~

- ~~Health information technology expenses to support these activities (Report in Column 5 – See instructions).~~

Column 5 – HIT Expenses for Health Care Quality Improvements

The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways:

1. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history;

3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or

5. Provision of electronic health records and patient portals.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to

meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements.

Expense Allocation

Supplemental Filing: A single (not state-by-state), separate, regulator only supplemental filing must be made by the insurer to provide a description of the method utilized to allocate QI expenses to each State and to each line and column on Part 3. Additionally, companies reporting QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing as well. For a new initiative that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an "X" in the "New" column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable results. Expenses for prospective Utilization Review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an "E" in the "New"

column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Notes: a. *Healthcare Professional Hotlines*: Expenses for health care professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.

b. *Prospective Utilization Review*: Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

~~The following items are broadly excluded as not meeting the definitions above:~~

- ~~All retrospective and concurrent Utilization Review;~~
- ~~Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes medical loss ratio recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);~~
- ~~The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;~~
- ~~Provider Credentialing;~~
- ~~Marketing expenses;~~
- ~~Any accreditation fees that are not directly related to activities included in Columns 1–5;~~
- ~~Costs associated with calculating and administering individual enrollee or employee incentives; and~~
- ~~Any function or activity not expressly included in Columns 1 through 5.~~

Note: The NAIC will review requests to include expenses for broadly excluded activities and activities not described under columns 1 through 5 above. Upon an adequate showing that the activity's costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.

Direct Claims Incurred

Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:

Line 2 – Direct Claims Incurred

Hospital/Medical Benefits

Include: Expenses for physician services provided under contractual arrangement to the reporting entity.

~~Salaries, including fringe benefits, paid to physicians for delivery of medical services. Capitation payments by the reporting entity to physicians for delivery of medical services to reporting entity subscribers.~~

~~Fees paid by the reporting entity to physicians on a fee-for-service basis for delivery of medical services to reporting entity subscribers. This includes capitated referrals.~~

~~Inpatient hospital costs of routine and ancillary services for reporting entity members while confined to an acute care hospital.~~

~~Charges for non-reporting entity physician services provided in a hospital are included in this line item only if included as an undefined portion of charges by a hospital to the reporting entity. (If separately itemized or billed, physician charges should be included in outside referrals, below).~~

~~The cost of utilizing skilled nursing and intermediate care facilities.~~

~~Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.~~

~~Ancillary services may also include laboratory, radiology, drugs, delivery room, physical therapy services, other special items and services for which charges are customarily made in addition to a routine service charge.~~

~~Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care or rehabilitation service.~~

~~Intermediate care facilities are for individuals who do not require the degree of care and treatment that a hospital or skilled nursing care facility provides, but that do require care and services above the level of room and board.~~

~~*Other Professional Services*~~

~~*Include*: Expenses for other professional providers under contractual arrangement to the reporting entity.~~

~~Salaries, as well as fringe benefits, paid by the reporting entity to non-physician providers licensed, accredited or certified to perform specified clinical health services, consistent with state law, engaged in the delivery of medical services to reporting entity enrollees. Capitation payments by the reporting entity to such clinical services.~~

~~Compensation to personnel engaged in activities in direct support of the provision of medical services.~~

~~*Exclude:* Professional services not meeting this definition. Report these services as administrative expenses. For example, exclude compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks.~~

~~*Outside Referrals*~~

~~*Include*: Expenses for providers not under arrangement with the reporting entity to provide services, such as consultations, or out-of-network providers.~~

~~*Emergency Room and Out-of-Area*~~

~~*Include*: Expenses for other health delivery services including emergency room costs incurred by members for which the reporting entity is responsible and out-of-area service costs for emergency physician and hospital.~~

~~In the event a member is admitted to a health care facility immediately after seeking emergency room service, emergency service expenses are reported in this line, the expenses after admission are reported in the hospital/medical line, provided the member is seeking services in the service area. Out-of-area expenses incurred, whether emergency or hospital, are reported in this line.~~

~~*Aggregate Write-ins for Other Hospital and Medical*~~

~~**Incurred Medical Pool Incentives and Bonuses**~~

~~**Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:**~~

~~Line 2.8 – Incurred Medical Incentive Pools and Bonuses~~

~~Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to share savings with contracted providers.~~

~~**Net Healthcare Receivables**~~

~~**Derived from SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 2:**~~

~~Line 2.9 – Net Healthcare Receivables~~

~~Report the change between prior year healthcare receivables and current year healthcare receivables. The amounts on this line are the gross healthcare receivable assets, not just the admitted portion. This amount should not include those health care receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.~~

20:06:22:27. Rating bands. With respect to the premium rate a health insurance issuer charges for health insurance coverage offered in the individual or small group market, the rate may only vary with respect to the particular plan or coverage involved by the following factors:

(1) Whether the plan or coverage covers an individual or a family;

(2) Rating area;

(3) Age, except the rate may not vary by more than 3:1 for like individuals of different age who are age 21 and older. The variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under § 20:06:22:30. For purposes of identifying the appropriate age adjustment under this subdivision and the age band in § 20:06:22:31, applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal shall be used; and

(4) Tobacco use, except such rate may not vary by more than 1.5:1 for like individuals who vary in tobacco usage and may only be applied with respect to individuals who may legally use tobacco under state law.

The rate may not vary with respect to the particular plan or coverage involved by any other factor not described in this section.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:27.01. Tobacco use defined. For purposes of § 20:06:22:27, tobacco use means use of any tobacco product on average four or more times per week within no longer than the past six months. Tobacco use does not include religious or ceremonial use of tobacco. Tobacco use must be defined in terms of when a tobacco product was last used.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:27.02. Tobacco usage reporting. If an enrollee is found to have reported false or incorrect information about their tobacco use, the issuer may retroactively apply the appropriate tobacco use rating factor to the enrollee's premium as if the correct information had been accurately reported from the beginning of the plan year. An issuer must not rescind the coverage on this basis. Tobacco use is not a material fact for which an issuer may rescind coverage if there is a misrepresentation.

Source:

General Authority: SDCL 58-17-87(5), 58-17-87, 58-17-4.2, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-18B-18, 58-18B-36, 58-17-87, 58-17-4.3

20:06:22:28. Health status and gender factors precluded. A health insurance issuer may not use health status or gender as a factor in any premium rate in the individual or small group market.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:29 Rating area. No health insurance issuer may vary rates based on geographical location in this state except as permitted by this section. The rating areas are on a county basis and are as follows:

(1) Harding, Butte, Perkins, Corson, Dewey, Ziebach, Haakon, Jackson, Bennett, Shannon, Fall River, Custer, Pennington, Lawrence, Meade, Stanley, Jones, Lyman, Mellette, Todd, Tripp and Gregory;

(2) Lake, Moody, McCook, Minnehaha, Turner, Lincoln, Clay, and Union;

(3) Campbell, Walworth, Potter, McPherson, Edmunds, Faulk, Brown, Spink, Marshall, Roberts, Day, Grant, Codington, Clark, Hamlin, Deuel, Brookings, Kingsbury, and Beadle; and

(4) Sully, Hughes, Hyde, Hand, Buffalo, Jerauld, Sanborn, Miner, Brule, Aurora, Davison, Hanson, Douglas, Charles Mix, Hutchinson, Bon Homme and Yankton.

Nothing in this section requires a health insurance issuer to use a different geographic rating factor for each rating area. A health insurance issuer may assign the same rating band for any or all of the rating areas specified in this section.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:30. Rating variations. With respect to family coverage under a health insurance plan, the rating variations permitted under §§ 20:06:22:27(3) and 20:06:22:27 (4), must be applied based on the portion of the premium attributable to each family member covered under the coverage. The total premium for family coverage must be determined by summing the premiums for each individual family member. In determining the total premium for family members, premiums for no more than the three oldest covered children who are under age 21 may be taken into account.

In the case of the small group market, the total premium charged to the group shall be determined by summing the premiums of covered participants and beneficiaries in accordance with this section.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:31. Uniform age bands. For rating purposes under § 20:06:22:27(3) uniform age bands are as follows:

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and Older	ARSD 20:06:46

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:32. Single risk pool. For the individual market, a health insurance issuer shall consider the claims experience of all individual health plans, other than those enrolled in grandfathered health plans and group plans subject to SDCL 58-17-70 , and excepted benefits offered by such issuer in the individual market in a state, including those enrollees who do not enroll in such plans through an Exchange, to be members of a single risk pool.

For the small group market, a health insurance issuer shall consider the claims experience of all enrollees in all health plans, other than grandfathered health plans, subject to SDCL 58-18B and offered by such issuer in the small group market in a state, including those enrollees who do not enroll in such plans through an Exchange, to be members of a single risk pool.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:33. Index rate. Each plan year or policy year, as applicable, each health insurance issuer shall establish its own index rate for this state based on the total combined claims costs for providing essential health benefits within the single risk pool of this state. Separate single risk pools are required for the individual and small group markets. Each

health insurance issuer shall adjust the index rate on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in this state. The premium rate for all the plans the of the health insurance issuer offers in this state market must use the applicable index rate, as adjusted for total expected market-wide payments and charges under the risk adjustment and reinsurance programs, subject only to the adjustments permitted under § 20:06:22:34.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:34. Permitted plan-level adjustments to the index rate. For each plan year or policy years beginning after December 31, 2013, a health insurance issuer may vary premium rates for a particular plan from its index rate for a relevant market in this state based only on the following actuarially justified plan specific factors:

(1) The actuarial value and costsharing design of the plan;

(2) The plan's provider network, delivery system characteristics, and utilization management practices;

(3) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to

determine rate variations for plans that offer those benefits in addition to essential health benefits;

(4) Administrative costs, excluding Exchange user fees; and

(5) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:22:35. Applicability. The provisions of §§ 20:06:22:27 to 20:06:22:34, inclusive apply for plan years beginning after December 31, 2013 in the small group market and for policy years beginning after December 31, 2013 for the individual market. The provisions of §§ 20:06:22:27 to 20:06:22:34, inclusive, do not apply to grandfathered health plans.

Effective January 1, 2014 the provisions of §§ 20:06:22:27 to 20:06:22:34, inclusive apply to any individual plan, group or small employer plan other than excepted benefits as defined in § 20:06:55:27 and grandfathered plans.

Source:

General Authority: SDCL 58-17-4.2, 58-17-87, 58-18B-18, 58-18B-36.

Law Implemented: SDCL 58-17-87, 58-17-4.3, 58-18B-18, 58-18B-36.

20:06:33:02. Form and content of access plans. Each initial filing of an access plan pursuant to SDCL 58-17F-10 must contain the following:

(1) A complete copy of the entire access plan;

(2) A complete copy of the current provider network in place listed by specialty and location;

(3) Any formalized steps that a covered person must utilize to obtain a referral;

(4) An annual survey, or other method approved by the director, to assess the satisfaction of covered persons that includes, at a minimum, questions designed to elicit how the covered person is generally satisfied and how the covered person feels the managed care plan meets the covered person's health care needs;

(5) In addition to the description of the method for informing covered persons required pursuant to SDCL subdivision 58-17F-10(5), a copy of the disclosure required by SDCL 58-17F-4, a copy of the health carrier's grievance procedures, a summary of utilization review procedures

provided to prospective covered persons, and a copy of the membership card pursuant to SDCL 58-17H-33;

(6) A copy of any written materials provided to covered persons that would generally inform such persons of the systems or processes that may be used to change primary care professionals as required by SDCL subdivision 58-17F-10(7);

(7) In conjunction with the plan for providing continuity of care as required by SDCL subdivision 58-17F-10(8), a copy of the language used in any provider contract that pertains to continuity of care; and

(8) A specimen copy of all provider contracts.

Discounted fee for service plans are not required to comply with subdivisions (3), (4), and (7). Discounted fee for service plans are not required to comply with subdivision (6) if the plan does not use or require the use of primary care professionals. Stand-alone dental plans are not required to comply with subdivisions (3), (4), (6) and (7).

Source: 26 SDR 64, effective November 14, 1999; 37 SDR 241, effective July 1, 2011; 38 SDR 59, effective October 19, 2011.

General Authority: SDCL 58-17F-10, 58-17F-21.

Law Implemented: SDCL 58-17F-4, 58-17F-10, 58-17F-21.

20:06:33:03. Annual filing of access plans. ~~Unless otherwise requested by the director, a health carrier making an annual filing of an access plan after the initial filing is only required to~~

~~file any changes to the access plan made since the last filing.~~ A health insurance issuer is required to either file any changes or an attestation stating no changes have been made, annually on or before September 30th of each year of their access plan filing.

Source: 26 SDR 64, effective November 14, 1999; 37 SDR 241, effective July 1, 2011.

General Authority: SDCL 58-17F-10, 58-17F-21.

Law Implemented: SDCL 58-17F-4, 58-17F-10, 58-17F-21.

CHAPTER 20:06:39

INDIVIDUAL PLANS

Section

20:06:39:06	College plans -- Bona fide association plans. Repealed January 1, 2014.
20:06:39:06.01	College plans -- Bona fide association plans. Effective January 1, 2014.
20:06:39:07	Requirements for breaks in coverage when applying for a new policy.
20:06:39:08	Active marketing required. Repealed January 1, 2014.
20:06:39:08.01	Active marketing required. Effective January 1, 2014.
20:06:39:09	Prohibited practices.
20:06:39:10	Prohibited compensation arrangements.
20:06:39:11 to 20:06:39:18	Repealed.
20:06:39:19	Guaranteed issue -- Effective date of coverage.
20:06:39:20	Guaranteed issue -- Tolling of 63-day time frame.
20:06:39:20.01 to 20:06:39:20.04	Repealed.
20:06:39:20.05	Effective date of guaranteed issue plan.

20:06:39:20.06	~~Notice requirements regarding guaranteed issue when rejecting applications.~~ Repealed.
20:06:39:21	Definition of ordinarily prudent person in preexisting condition clauses.
20:06:39:22	Fair market standards for carrier.
20:06:39:23	Group applicability to individual market.
20:06:39:24	~~Requirements for standard plan -- Schedule of benefits.~~ Repealed.
20:06:39:25	~~Requirements for standard plan -- Eligible expenses.~~ Repealed.
20:06:39:26	~~Requirements for standard plan -- Allowable exceptions and limitations.~~ Repealed.
20:06:39:27	Requirements for basic plan -- Schedule of benefits. Repealed.
20:06:39:28	~~Requirements for basic plan -- Eligible expenses~~. Repealed.
20:06:39:29	~~Requirements for basic plan -- Allowable exceptions and limitations.~~ Repealed.

20:06:39:30	Usual, customary, and reasonable charges for standard and basic plans.
20:06:39:31	Network available for standard and basic plans. Repealed.
20:06:39:32	Contract of more than six months -- Defined.
20:06:39:33	Coverages prior to August 1, 2003. Repealed.
20:06:39:34	Disclosure requirements. Repealed January 1, 2014.
20:06:39:34.01	Disclosure requirements. Effecitve January 1, 2014.
20:06:39:35	Policy not subject to group requirements.
20:06:39:36	Medically necessary leave of absence defined.
20:06:39:37	Dependent coverage.
20:06:39:38	Notification.
20:06:39:39	Continued application in case of changed coverage.
20:06:39:40	Effective date.
20:06:39:41	Creditable coverage -- Children's Health Insurance Program.

20:06:39:42	Association health insurance plans subject to individual market rating requirements.
20:06:39:43	Definitions.
20:06:39:44	Prohibition on genetic information in setting premium rates.
20:06:39:45	Limitation on requesting or requiring genetic testing.
20:06:39:46	Exceptions to requiring genetic testing.
20:06:39:47	Research exception.
20:06:39:48	Prohibitions on collection of genetic information for underwriting purposes.
20:06:39:49	Medical appropriateness.
20:06:39:50	Collection of genetic information prior to or in connection with enrollment.
20:06:39:51	Incidental collection exception.
20:06:39:52	Prohibition on genetic information as a condition of eligibility.
20:06:39:53	Prohibition on genetic information is preexisting condition.

20:06:39:54 Medicare supplemental health insurance.

20:06:39:55 Applicability to excepted benefits.

20:06:39:56 Effective date.

20:06:39:57 Guaranteed availability of coverage in the individual market.

20:06:39:58 Denial of coverage.

20:06:39:59 Open enrollment.

20:06:39:60 Initial open enrollment period.

20:06:39:61 Annual open enrollment period.

20:06:39:62 Special enrollment period effective dates.

20:06:39:63 Waiting period.

20:06:39:64 Enrollment in catastrophic plans.

20:06:39:65 Student health insurance coverage.

20:06:39:66 Clinical trial.

20:06:39.67 Nonrenewal of coverage.

20:06:39:68 Discontinuing a particular product.

20:06:39:69 Discontinuing all coverage.

20:06:39:70 Special enrollment periods for marriage, birth, and adoption.

20:06:39:71 Special enrollment triggers.

20:06:39:72 Preexisting condition exclusion and waiting period prohibited.

20:06:39:73 Applicability.

Appendix A Example of Certificate of Individual Health Insurance Coverage.

Appendix B Notice of Research Exception.

~~**20:06:39:04. Certificates required upon loss of coverage.** A carrier must automatically provide a certificate containing language that is substantially similar to the language contained in Appendix A at the end of this chapter to any individual losing coverage. At any time within 24 months after coverage ceases, a carrier must also provide additional certificates pursuant to requests by or on behalf of an individual. Each certificate must be provided in a reasonable and prompt fashion. A separate fee may not be charged for the provision of a certificate, but the cost of this service may be factored into the policy premium.~~

~~After July 1, 1998, a carrier must provide certificates as required in this section for dependents as well as the individual to whom the coverage was issued. Before July 1, 1998, a carrier may satisfy the requirement for certificates identifying coverage for dependents by providing the name of the policyholder and specifying that family coverage is in force. Before July 1, 1998, if the carrier is requested to provide a certificate for a dependent, the carrier must make reasonable efforts to obtain and provide the name of the dependent.~~

~~If a carrier provides coverage in connection with another type of creditable coverage, the carrier must provide a certificate as required by this section. A carrier may, for an individual with at least 12 months of creditable coverage without a break in coverage exceeding 63 days, simply certify that the individual has 12 months of creditable coverage~~.Repealed January 1, 2014.

~~**Source:** 24 SDR 35, effective September 29, 1997.~~

~~**General Authority:** SDCL 58-17-87(2).~~

~~**Law Implemented:** SDCL 58-11-1, 58-17-85, 58-17-87, 58-33-36.~~

20:06:39:04.01. Certificates required upon loss of coverage. Effective January 1, 2014. A health insurance issuer must automatically provide a certificate of creditable coverage to any individual losing coverage. At any time within 24 months after coverage ceases, a health insurance issuer must also provide additional certificates pursuant to requests by or on behalf of an individual. Each certificate must be provided in a reasonable and prompt fashion. A separate fee may not be charged for the provision of a certificate, but the cost of this service may be factored into the policy premium.

After July 1, 1998, a health insurance issuer must provide certificates as required in this section for dependents as well as the individual to whom the coverage was issued. Before July 1, 1998, a health insurance issuer may satisfy the requirement for certificates identifying coverage for dependents by providing the name of the policyholder and specifying that family coverage is in force. Before July 1, 1998, if the health insurance issuer is requested to provide a certificate for a dependent, the health insurance issuer must make reasonable efforts to obtain and provide the name of the dependent.

If a health insurance issuer provides coverage in connection with another type of creditable coverage, the health insurance issuer must provide a certificate as required by this section. A

health insurance issuer may, for an individual with at least 12 months of creditable coverage without a break in coverage exceeding 63 days, simply certify that the individual has 12 months of creditable coverage.

Source:.

General Authority: SDCL 58-17-87(2).

Law Implemented: SDCL 58-11-1, 58-17-85, 58-17-87, 58-33-36.

20:06:39:06. College plans -- Bona fide association plans. ~~A college plan is an association plan that provides coverage to students of a college or university. A college plan that is a limited benefit plan or contains excepted benefits as specified in 45 C.F.R. § 148.220 as published on 62 Fed. Reg. 17,004 (April 8, 1997) is not subject to the provisions of SDCL 58-17-66 to 58-17-87, inclusive, and is not considered creditable coverage under SDCL 58-17-69 and 58-18-44. Other college plans are subject to the provisions of SDCL 58-17-69 to 58-17-87, inclusive, and are considered creditable coverage as provided for in SDCL 58-17-69 and 58-18-44. However, a college plan that is a bona fide association plan under SDCL 58-18B-48 is not required to renew coverage once the covered individual is no longer a student and is not required to issue coverage pursuant to SDCL 58-17-85.~~ Repealed January 1, 2014

Source: 24 SDR 35, effective September 29, 1997.

~~**General Authority:** SDCL 58-17-87(1),(2),(3),(4).~~

~~**Law Implemented:** SDCL 58-17-69, 58-17-70, 58-17-82, 58-17-85, 58-17-87.~~

20:06:39:06.01 Student health plans -- Bona fide association plans. A student health plan is an association plan that provides coverage to students of a college or university. A student health plan that is a bona fide association plan under SDCL 58-18B-48 is not required to renew coverage once the covered individual is no longer a student and is not required to issue coverage pursuant to SDCL 58-17-85.

Source:

General Authority: SDCL 58-17-87(1),(2),(3),(4).

Law Implemented: SDCL 58-17-69, 58-17-70, 58-17-82, 58-17-85, 58-17-87.

~~**20:06:39:08. Active marketing required.** No health carrier may directly or indirectly discourage applicants from exercising their open enrollment rights under § 20:06:55:25. Health carriers may not in any manner penalize agents for submitting applications for those qualifying for open enrollment under § 20:06:55:25. An individual health carrier, which was actively marketing health benefit plans to persons under the age of 19 as of March 23, 2010, and discontinues actively marketing that coverage to those under the age of 19, may not continue to issue any individual health benefit plans in this state until such time as coverage is again actively marketed to those under the age of 19. A health carrier that is a new entrant to the individual health benefit plan market in this state must, as a condition of offering coverage to any adults, offer coverage to those under the age of 19 as provided by this section and § 20:06:55:25. If the provisions of § 20:06:55:25, with respect to permitting underwriting non open enrollment periods, are no longer in effect, the requirement in this section that an individual health carrier~~

~~actively market to those under the age of 19 is not applicable. A health carrier is not required to actively market coverage to those under the age of 19 if application is made to and approved by the director showing that the health carrier has either accepted a disproportionate share of high risk individuals under the age of 19 or the continued offering of health benefit plans to those under the age of 19 would jeopardize its financial solvency.~~ Repealed January 1, 2014.

Source: 24 SDR 86, effective December 31, 1997; 37 SDR 63, effective September 23, 2010; 37 SDR 111, effective December 7, 2010.

~~**General Authority:** SDCL 58-17-87(6).~~

~~**Law Implemented:** SDCL 58-17-87(6).~~

20:06:39:08.01 Active marketing required. No health insurance issuer may directly or indirectly discourage applicants from exercising their open enrollment rights under § 20:06:39:59. No health insurance issuer may, in any manner penalize agents for submitting applications for those qualifying for open enrollment under § 20:06:39:59. If a health insurance issuer in the individual market offers health insurance coverage in any level of coverage specified under section 1302(d)(1) of PPACA as defined in § 20:06:55:32, the issuer must offer coverage in that level to individuals who, as of the beginning of a plan year, have not attained the age of 21.

Source:

General Authority: SDCL 58-17-87(6).

Law Implemented: SDCL 58-17-87(6).

20:06:39:20.06. Notice requirements regarding guaranteed issue when rejecting applications. ~~Any carrier rejecting an application for a health benefit plan, whether the application is on an underwritten or guaranteed issue basis, must include the following in any notice or letter of rejection of the application:~~

~~"In order to preserve eligibility that you may have for guaranteed issue of a health insurance policy, a subsequent application must be made within 30 days of the receipt of this notice of rejection or within 63 days of the date of loss of prior creditable coverage, whichever is later. For details or assistance, you are encouraged to contact your agent."~~

~~The letter or notice of rejection is presumed received five days after the date of mailing by the carrier.~~ Repealed.

Source: 28 SDR 158, effective May 19, 2002.

~~**General Authority:** SDCL 58-17-85, 58-17-87(2).~~

~~**Law Implemented:** SDCL 58-17-85.~~

20:06:39:24. Requirements for standard plan -- Schedule of benefits. ~~The schedule of benefits for the standard plan are as follows:~~

~~(1) A deductible per person of at least $1,000 but not more than $5,000. Carriers must offer at least the $1,000 and the $5,000 deductible options;~~

~~(2) An emergency room deductible of $50 for each emergency room visit unless the person is subsequently admitted as an inpatient. The emergency room deductible applies toward meeting the out-of-pocket maximum;~~

~~(3) A coinsurance maximum of $2,000 per person. The percentage of coinsurance is 20 percent of the eligible charges for covered services received from participating or nonparticipating providers;~~

~~(4) A lifetime benefits maximum of:~~

~~(a) $1,000,000 per person;~~

~~(b) $250,000 for the treatment of AIDS/HIV;~~

~~(c) 90 days of inpatient treatment for alcoholism;~~

~~(d) 50 percent of covered charges up to a $10,000 maximum for the outpatient treatment of alcoholism and chemical dependency. There is a $50 maximum fee for each outpatient visit;~~

~~(e) $10,000 for the inpatient treatment of chemical dependency, excluding the treatment of alcoholism; and~~

~~(f) A lifetime transplant maximum of $100,000 per person for all heart, heart and lung, single lung, liver, pancreas, kidney and pancreas, bone marrow, and stem cell transfers transplants. Cornea or kidney transplants are not subject to the lifetime transplant maximum.~~

~~All of the limits in (4)(b) to (4)(f), inclusive, in this section may apply toward meeting the $1,000,000 lifetime maximum per person.~~ Repealed.

Source: 27 SDR 69, effective January 15, 2001.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-85.~~

20:06:39:25. Requirements for standard plan -- Eligible expenses. ~~The eligible expenses for the standard plan are as follows:~~

~~(1) Accidental injury services;~~

~~(2) Anesthetics and their administration. Payment for anesthesia given by the operating physician or the surgical assistant is limited to 50 percent of the usual, customary, and reasonable (UCR) amount or the allowable charge, whichever is applicable;~~

~~(3) Assisting surgeon services;~~

~~(4) Treatment and diagnosis of biologically-based mental illnesses with the same dollar limits, deductibles, coinsurance factors, and restrictions as for other covered illnesses;~~

~~(5) Chemotherapy services for treatment of a malignancy;~~

~~(6) Concurrent care for the treatment of more than one medical condition, but not for two or more practitioners to treat the same condition, unless medically necessary;~~

~~(7) Consultation services of a medical, surgical, obstetrical, pathological, or radiological consultant when requested by the attending practitioner. The consultation must include an actual physical examination, and any services ordered or performed must be documented in the patient's medical record and communicated to the requesting practitioner;~~

~~(8) Dental services, limited to accidental injuries which occur while the person is covered under this policy and which are treated within six months of the injury. Injuries associated with or resulting from the act of chewing are never covered. Anesthesia and hospitalization for dental care for persons who are under age five or are severely disabled will also be covered;~~

~~(9) Diabetes supplies, equipment, and education, as required by SDCL 58-17-1.2;~~

~~(10) Emergency air or ground ambulance to the nearest hospital capable of handling the emergency;~~

~~(11) Hemodialysis services when provided to an inpatient of a hospital or an outpatient in a Medicare-approved dialysis center;~~

~~(12) Maternity services for the covered person or the covered person's spouse for complications of pregnancy only;~~

~~(13) Medical services (other than surgical or obstetrical) provided by a practitioner to an inpatient or an outpatient. Home and office calls are covered;~~

~~(14) Medical supplies including prescription drugs, oxygen, rental of durable medical equipment up to the purchase price, surgical dressings, casts, splints, braces, and crutches;~~

~~(15) Occupational and physical therapy;~~

~~(16) Physicians services, including surgery;~~

~~(17) Prosthetic appliances used to replace a missing, natural part of the body and braces used to support or restrict movement of weakened or deformed body parts;~~

~~(18) Radiation therapy;~~

~~(19) Room, board, and general nursing care during hospital inpatient confinement, but not to exceed the average semi-private room charge of the hospital;~~

~~(20) Miscellaneous hospital services including outpatient services;~~

~~(21) Surgical services which include operative and cutting procedures, major endoscopic procedures, and preoperative and postoperative care. Payment for multiple surgical procedures, not including the primary surgical procedure, performed at the same time may be reduced to 50 percent of the allowable charge or the usual, customary, and reasonable (UCR) amount, whichever is applicable. If the multiple surgical procedure is determined incidental, benefits will be denied;~~

~~(22) X-ray and laboratory services for the diagnosis and treatment of an illness or injury. Coverage would include routine mammography x-ray as required by SDCL 58-17-1.1;~~

~~(23) Breast reconstruction in connection with mastectomy, which includes:~~

~~(a) Reconstruction of the breast on which the mastectomy was performed;~~

~~(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and~~

~~(c) Prostheses and physical complications at all stages of a mastectomy, including lymphedemas; and~~

~~(24) Hospice.~~ Repealed.

Source: 27 SDR 69, effective January 15, 2001.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-85.~~

20:06:39:26. Requirements for standard plan -- Allowable exceptions and limitations. ~~The allowable exceptions and limitations for the standard plan are as follows:~~

~~(1) Non-emergency weekend hospital admission or confinement for tests which could have been performed on an outpatient pre-admission basis, unless a prudent lay person acting reasonably would have believed that an emergency medical condition existed;~~

~~(2) Pregnancy or childbirth, except for complications of pregnancy as defined in the policy or as required by state law;~~

~~(3) Infertility diagnosis and treatment, including any attempt to induce fertilization by any method other than by natural means, including reversal of sterilization, diagnosis and treatment of recurrent abortion, in vitro fertilization, embryo transplants, artificial insemination, or similar procedures whether the covered person is the donor, recipient, or surrogate;~~

~~(4) Contraceptive methods, aids, or devices, and elective sterilization or elective abortion, unless the life of the mother is endangered;~~

~~(5) Sex transformation, sexual identification, and any treatment for sexual dysfunction or disorder and complications thereof;~~

~~(6) Breast reduction or augmentation, and implantation, removal, or correction of breast implants which were implanted for cosmetic reasons except as provided by § 20:06:39:23;~~

~~(7) Genetic testing or therapy, except as required by law;~~

~~(8) Growth hormones;~~

~~(9) Weight modification, including services, supplies, or treatment related to organized programs, treatment for obesity by diet drugs, any form of surgery or complications of surgery, and any exercise program or equipment;~~

~~(10) Liposuction, lipectomy, or plasty of skin or subcutaneous tissue;~~

~~(11) Treatment of weak, strained, flat, unstable, or unbalanced feet; metatarsalgia, bunions, or the removal of one or more corns or calluses; and onychomycosis and/or disease or disorder of the nails;~~

~~(12) Varicose veins or vericocele;~~

~~(13) Bereavement counseling or services, or services of volunteers or clergy;~~

~~(14) Childhood disorders as conditions related to autistic disease of childhood, hyperkenetic syndromes, learning disabilities, or behavioral problems, or for inpatient confinement for environmental change;~~

~~(15) Marriage and family counseling or other training services;~~

~~(16) Services or supplies which are required to treat an injury suffered due to any act of war, declared or undeclared, when the covered person is on active or reserve duty or in the military corps;~~

~~(17) Complications of a noncovered procedure;~~

~~(18) Services or supplies that are received before the effective date of coverage under the policy or contract;~~

~~(19) Elastic stockings and bandages including trusses, lumbar braces, garter belts, and similar items which can be purchased without a prescription;~~

~~(20) Medical care or services received while outside of the United States, except for an emergency;~~

~~(21) Hearing aids and related fittings, prescriptions, or hearing exams;~~

~~(22) Services or supplies that are considered investigational. Treatment is considered investigational when the service, procedure, drug, or treatment modality has progressed to limited human application, but has not achieved recognition as being proven and effective in clinical medicine;~~

~~(23) Maxillary and mandibular implants (osseointegration);~~

~~(24) Services and supplies which are not medically necessary;~~

~~(25) Telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for medical information;~~

~~(26) Private duty nursing services;~~

~~(27) Services or supplies related to respite care;~~

~~(28) Care and treatment of any injury that is intentionally self-inflicted, while sane or insane;~~

~~(29) Services or supplies for treatment of temporomandibular joint pain or syndrome (TMJ), myofascial pain syndrome, and craniomandibular joint dysfunction;~~

~~(30) Services or supplies incurred after the date of termination of the policy or contract;~~

~~(31) Orthoptics (eye-muscle exercises), eyeglasses, contact lenses, exams for a fitting or prescription (including vision exercises), or surgery to correct eye refractions, such as keratotomies;~~

~~(32) Services or supplies for screening examinations including x-ray examinations made without film, unless specifically covered in the policy or contract;~~

~~(33) Services or supplies when the covered person is paid claim benefits from governmental programs (except Medicaid);~~

~~(34) Sickness or injury due to intoxication or use of illegal drugs, but only if the covered person is committing a felony at the time of loss;~~

~~(35) When someone else has the legal obligation to pay for the covered person's care, and when in the absence of the policy or contract the covered person would not be charged;~~

~~(36) Services or supplies received if the covered person has suffered an injury or illness for which benefits are paid by workers' compensation;~~

~~(37) Acupuncture services or supplies;~~

~~(38) Cosmetic services or supplies that are primarily to improve the covered person's natural appearance;~~

~~(39) Custodial or sanitaria care or rest cures; respite care; convalescent care; rehabilitation; or training, schooling, or occupational therapy;~~

~~(40) Orthomolecular therapy, including nutrients, vitamins, and food supplements;~~

~~(41) Self-help or self-cure programs, including prescription gum or patches used for the purpose of smoking cessation;~~

~~(42) Speech therapy, except to restore speech abilities which were lost due to sickness or injury;~~

~~(43) Nonbiologically-based mental illnesses;~~

~~(44) Home health services;~~

~~(45) Chelation;~~

~~(46) Nonhuman transplants;~~

~~(47) Biofeedback;~~

~~(48) Massage therapy; and~~

~~(49) Any eligible expenses paid under another insurance, governmental, or benefit plan.~~ Repealed.

Source: 27 SDR 69, effective January 15, 2001.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-85.~~

20:06:39:27. Requirements for basic plan -- Schedule of benefits. ~~The schedule of benefits for the basic plan are as follows:~~

~~(1) A deductible per person of at least $1,000 but nor more than $5,000. Carriers must offer at least the $1,000 and the $5,000 deductible options;~~

~~(2) An emergency room deductible of $50 for each emergency room visit unless the person is subsequently admitted as an inpatient. The emergency room deductible applies toward meeting the out-of-pocket maximum;~~

~~(3) A coinsurance maximum of $4,000 per person. The percentage of coinsurance is 40 percent of the eligible charges for covered services received from participating or nonparticipating providers; and~~

~~(4) A lifetime benefits maximum of:~~

~~(a) $1,000,000 per person;~~

~~(b) $250,000 for the treatment of AID/HIV;~~

~~(c) 90 days of inpatient treatment for alcoholism;~~

~~(d) 50 percent of covered charges up to a $10,000 maximum for the outpatient treatment of alcoholism and chemical dependency. There is a $50 maximum fee for each outpatient visit; and~~

~~(e) $10,000 for the inpatient treatment of chemical dependency, excluding the treatment of alcoholism.~~

~~All of the limits in (4)(b) to (4)(e), inclusive, in this section may apply toward meeting the $1,000,000 lifetime maximum per person.~~ Repealed.

Source: 27 SDR 69, effective January 15, 2001.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-85.~~

20:06:39:28. Requirements for basic plan -- Eligible expenses. ~~The eligible expenses for the basic plan are as follows:~~

~~(1) Accidental injury services;~~

~~(2) Anesthetics and their administration. Payment for anesthesia given by the operating physician or the surgical assistant is limited to 50 percent of the allowable charge or usual, customary, and reasonable (UCR) amount, whichever is applicable;~~

~~(3) Assisting surgeon services;~~

~~(4) Treatment and diagnosis of biologically-based mental illnesses with the same dollar limits, deductibles, coinsurance factors, and restrictions as for other covered illnesses;~~

~~(5) Chemotherapy services for treatment of malignancy;~~

~~(6) Concurrent care for the treatment of more than one medical condition, but not for two or more practitioners to treat the same condition, unless medically necessary;~~

~~(7) Consultation services of a medical, surgical, obstetrical, pathological, or radiological consultant when requested by the attending practitioner. The consultation must include an actual physical examination, and any services ordered or performed must be documented in the patient's medical record and communicated to the requesting practitioner;~~

~~(8) Dental services, limited to accidental injuries which occur while the person is covered under this policy and which are treated within six months of the injury. Injuries associated with or resulting from the act of chewing are never covered. Anesthesia and hospitalization for dental care for persons who are under age five or are severely disabled will also be covered;~~

~~(9) Diabetes supplies, equipment, and education, as required by SDCL 58-17-1.2;~~

~~(10) Emergency air or ground ambulance to the nearest hospital capable of handling the emergency;~~

~~(11) Hemodialysis services when provided to an inpatient of a hospital or an outpatient in a Medicare approved dialysis center;~~

~~(12) Maternity services for the covered person or the covered person's spouse for complications of pregnancy only;~~

~~(13) Medical services (other than surgical or obstetrical) provided by a practitioner to an inpatient or an outpatient. Home and office calls are covered;~~

~~(14) Medical supplies including oxygen, rental of durable medical equipment up to the purchase price, surgical dressings, casts, splints, braces, and crutches;~~

~~(15) Occupational and physical therapy;~~

~~(16) Physicians services, including surgery;~~

~~(17) Prosthetic appliances used to replace a missing, natural part of the body and braces used to support or restrict movement of weakened or deformed body parts;~~

~~(18) Radiation therapy;~~

~~(19) Room, board, and general nursing care during hospital inpatient confinement, but not to exceed the average semi-private room charge of the hospital;~~

~~(20) Miscellaneous hospital services including outpatient services;~~

~~(21) Surgical services which include operative and cutting procedures, major endoscopic procedures and preoperative and postoperative care. Payment for multiple surgical procedures, not including the primary surgical procedure, performed at the same time may be reduced to 50 percent of the allowable charge or usual, customary, and reasonable (UCR) amount, whichever is applicable. If the multiple surgical procedure is determined incidental, benefits will be denied;~~

~~(22) X-ray and laboratory services for the diagnosis and treatment of an illness or injury. Coverage would include routine mammography x-ray as required by SDCL 58-17-1.1;~~

~~(23) Breast reconstruction in connection with mastectomy, which includes:~~

~~(a) Reconstruction of the breast on which the mastectomy was performed;~~

~~(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and~~

~~(c) Prostheses and physical complications at all stages of a mastectomy, including lymphedemas; and~~

~~(24) Hospice~~. Repealed.

Source: 27 SDR 69, effective January 15, 2001.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-85.~~

20:06:39:29. Requirements for basic plan -- Allowable exceptions and limitations. ~~The allowable exceptions and limitations for the basic plan are as follows:~~

~~(1) Non-emergency weekend hospital admission or confinement for tests which could have been performed on an outpatient pre-admission basis, unless a prudent lay person acting reasonably would have believed that an emergency medical condition existed;~~

~~(2) Pregnancy or childbirth, except for complications of pregnancy as defined in the policy or contract or as required by state law;~~

~~(3) Infertility diagnosis and treatment, any attempt to induce fertilization by any method other than by natural means, including reversal of sterilization, diagnosis and treatment of~~

~~recurrent abortion, in vitro fertilization, embryo transplants, artificial insemination, or similar procedures whether the covered person is the donor, recipient, or surrogate;~~

~~(4) Contraceptive methods, aids, or devices, and elective sterilization or elective abortion, unless the life of the mother is endangered;~~

~~(5) Sex transformation, sexual identification, and any treatment for sexual dysfunction or disorder and complications thereof;~~

~~(6) Breast reduction or augmentation, and implantation, removal, or correction of breast implants which were implanted for cosmetic reasons except as provided by § 20:06:39:23;~~

~~(7) Genetic testing or therapy, except as required by law;~~

~~(8) Growth hormones;~~

~~(9) Weight modification, including services, supplies, or treatment related to organized programs, treatment for obesity by diet drugs, any form of surgery or complications of surgery, and any exercise program or equipment;~~

~~(10) Liposuction, lipectomy, or plasty of skin or subcutaneous tissue;~~

~~(11) Treatment of weak, strained, flat, unstable, or unbalanced feet; metatarsalgia, bunions, or the removal of one or more corns or calluses; and onychomycosis and/or disease or disorder of the nails;~~

~~(12) Varicose veins or vericocele;~~

~~(13) Bereavement counseling or services, or services of volunteers or clergy;~~

~~(14) Childhood disorders as conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, or behavioral problems, or for inpatient confinement for environmental change;~~

~~(15) Marriage and family counseling or other training services;~~

~~(16) Services or supplies which are required to treat an injury suffered due to any act of war, declared or undeclared, when the covered person is on active or reserve duty or when in the military corps;~~

~~(17) Complications of a noncovered procedure;~~

~~(18) Services or supplies that are received before the effective date of coverage under the policy or contract;~~

~~(19) Elastic stockings and bandages including trusses, lumbar braces, garter belts, and similar items which can be purchased without a prescription;~~

~~(20) Medical care or services received while outside of the United States, except for an emergency;~~

~~(21) Hearing aids and related fittings, prescriptions, or hearing exams;~~

~~(22) Services or supplies that are considered investigational. Treatment is considered investigational when the service, procedure, drug, or treatment modality has progressed to~~

~~limited human application, but has not achieved recognition as being proven and effective in clinical medicine;~~

~~(23) Maxillary and mandibular implants (osseointegration);~~

~~(24) Services and supplies which are not medically necessary;~~

~~(25) Telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for medical information;~~

~~(26) Private duty nursing services;~~

~~(27) Services or supplies related to respite care;~~

~~(28) Care and treatment of any injury that is intentionally self-inflicted, while sane or insane;~~

~~(29) Services or supplies for treatment of temporomandibular joint pain or syndrome (TMJ), myofascial pain syndrome, and craniomandibular joint dysfunction;~~

~~(30) Services or supplies incurred after the date of termination of the policy or contract;~~

~~(31) Orthoptics (eye-muscle exercises), eyeglasses, contact lenses, exams for a fitting or prescription (including vision exercises), or surgery to correct eye refractions, such as keratotomies;~~

~~(32) Services or supplies for screening examinations including x-ray examinations made without film, unless specifically covered in the policy or contract;~~

~~(33) Services or supplies when the covered person is paid claim benefits from governmental programs (except Medicaid);~~

~~(34) Sickness or injury due to intoxication or use of illegal drugs, but only if the covered person is committing a felony at the time of loss;~~

~~(35) When someone else has the legal obligation to pay for the covered person's care, and when in the absence of the policy or contract the covered person would not be charged;~~

~~(36) Services or supplies received if the covered person has suffered an injury or illness for which benefits are paid by workers' compensation;~~

~~(37) Acupuncture services or supplies;~~

~~(38) Cosmetic services or supplies that are primarily to improve the covered person's natural appearance;~~

~~(39) Custodial or sanitaria care or rest cures; respite care; convalescent care; rehabilitation; or training, schooling, or occupational therapy;~~

~~(40) Orthomolecular therapy, including nutrients, vitamins, and food supplements;~~

~~(41) Self-help or self-cure programs, including prescription gum or patches used for the purpose of smoking cessation;~~

~~(42) Speech therapy, except to restore speech abilities which were lost due to sickness or injury;~~

~~(43) Transplant services or supplies related to transplants, treatment, and complications including ambulance services for transplant;~~

~~(44) Nonbiologically-based mental illnesses;~~

~~(45) Home health services;~~

~~(46) Chelation;~~

~~(47) Non-human transplants;~~

~~(48) Biofeedback;~~

~~(49) Massage therapy; and~~

~~(50) Any eligible expenses paid under another insurance, governmental, or benefit plan.~~ Repealed.

Source: 27 SDR 69, effective January 15, 2001.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-85.~~

20:06:39:31. Network available for standard and basic plans. ~~If a health carrier has a preferred provider network available for other health insurance products, the carrier must make that network available for the standard and basic plans.~~ Repealed.

Source: 27 SDR 69, effective January 15, 2001.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-85.~~

20:06:39:33. Coverages prior to August 1, 2003. ~~The provisions of §§ 20:06:39:08, 20:06:39:09, 20:06:39:10, 20:06:39:19, 20:06:39:20, 20:06:39:20.05, 20:06:39:20.06, 20:06:39:24, 20:06:39:25, 20:06:39:26, 20:06:39:27, 20:06:39:28, 20:06:39:29, 20:06:39:30, and 20:06:39:31 only apply to coverages written before August 1, 2003.~~ Repealed.

Source: 32 SDR 232, effective July 10, 2006.

~~**General Authority:** SDCL 58-17-87(6).~~

~~**Law Implemented:** SDCL 58-17-87(6).~~

20:06:39:34. Disclosure requirements. ~~Any policy or certificate of specified disease, short term hospital-surgical care of six months or less duration but not including short term major medical, hospital confinement indemnity, limited benefit health insurance, or other policy or certificate that provides less benefits than as provided under SDCL 58-17-69(2) must clearly and prominently disclose that the policy is a limited benefit health insurance plan. The following is an example of a disclosure for limited benefit coverages that is in compliance provided it is prominent and otherwise meets the requirements of this section:~~

~~**This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits policy and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness.**~~

~~For short-term major medical policies clear and prominent disclosure of the preexisting condition limitation and the short term duration of the product must be made. The following notice is an example of a short term major medical disclosure that is in compliance provided it is prominent and otherwise meets the requirements of this section:~~

~~**This policy is a short term medical insurance [policy/certificate] which provides coverage for six months or less duration and excludes coverage for preexisting conditions.**~~

~~The disclosures required by this section must be contained on the first page of the policy. The requirements of this section also apply to outlines of coverage. Nothing in this section applies to Medicare supplement, long-term care, disability or credit health insurance coverages.~~Repealed January 1, 2014.

Source: 34 SDR 200, effective January 28, 2008; 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-17-87(6), 58-33A-7(13).~~

~~**Law Implemented:** SDCL 58-17-70, 58-33A-2(1), (3), (4), (6), and (10)~~

20:06:39:34.01 Disclosure requirements. Any policy or certificate of specified disease, short term hospital-surgical care of six months or less duration but not including short term major medical, hospital confinement indemnity, limited benefit health insurance, or other policy or certificate that provides less benefits than essential health benefits must clearly and prominently disclose that the policy is a limited benefit health insurance plan. The following is an example of a disclosure for limited benefit coverages that is in compliance provided it is prominent and otherwise meets the requirements of this section:

This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits policy and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness.

For short-term major medical policies clear and prominent disclosure of the preexisting condition limitation and the short term duration of the product must be made. The following notice is an example of a short term major medical disclosure that is in compliance provided it is prominent and otherwise meets the requirements of this section:

This policy is a short term medical insurance [policy/certificate] which provides coverage for six months or less duration and excludes coverage for preexisting conditions.

The disclosures required by this section must be contained on the first page of the policy. The requirements of this section also apply to outlines of coverage. Nothing in this section applies to Medicare supplement, long-term care, disability or credit health insurance coverages.

Source:

General Authority: SDCL 58-17-87(6), 58-33A-7(13).

Law Implemented: SDCL 58-17-70, 58-33A-2(1), (3), (4), (6), and (10)

20:06:39:37. Dependent coverage. Any ~~health carrier~~ health insurance issuer issuing a health benefit plan that provides dependent coverage for any qualifying child may not terminate coverage due to a medically necessary leave of absence for a period of twelve months after the first day of leave or the date on which such coverage would otherwise terminate under the terms of the plan, whichever is earlier. A qualifying child whose benefits are continued under this section is entitled to the same benefits as if the qualifying child continued to be a covered student and was not on a medically necessary leave of absence.

The health benefit plan must receive written certification of the medically necessary leave of absence by a treating physician of the qualifying child that states that the child is suffering

from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.

Source: 36 SDR 96, effective December 9, 2009.

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:42. Association health insurance plans subject to individual market rating requirements. ~~Any health carrier~~ A health insurance issuer issuing health policies or certificates to an association must file its premium rates in accordance with the requirements of SDCL 58-17-4.1 to 58-17-4.3, inclusive, and chapter 20:06:22. The requirements of this section apply to rates for any newly approved policies or certificates to be offered in this state and to any increase in premium rates for previously issued certificates that take effect after June 30, 2010. This section does not apply to any association plan exclusively issued to employers as members of an association, to any association plan that is an excepted benefit as defined by SDCL 58-17-69(13), or to any association plan which provides blanket health insurance.

Source: 36 SDR 209, effective July 1, 2010.

General Authority: SDCL 58-17-87(5).

Law Implemented: SDCL 58-17-4.1, 58-17-4.2, 58-17-4.3.

20:06:39:57. Guaranteed availability of coverage in the individual market. After December 31, 2013 a health insurance issuer that offers health insurance coverage in the individual market in this state must offer to any individual in the state all products that are approved for sale in the applicable market, and must accept any individual that applies for any of those products. Nothing in this section requires an issuer to offer or provide coverage outside its approved service area.

A health insurance issuer offering health insurance coverage in the individual market, other than excepted benefits, must ensure that such coverage includes the essential health benefits package as defined in § 20:06:56:03 effective for plan or policy years beginning after December 31, 2013 . Except for catastrophic plans, any plans not providing a bronze level of coverage must be issued as a supplement to other health insurance coverage and may not be used to replace essential health benefits coverage, a grandfathered health benefit plan or a catastrophic plan.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:58. Denial of Coverage. After December 31, 2013 a health insurance issuer may deny health insurance coverage in the individual market outside the Exchange if the issuer has demonstrated to the director the following:

(1) The health insurance issuer does not have the financial reserves necessary to underwrite additional coverage;

(2) The health insurance issuer is applying the denial uniformly to all individuals in the individual market without regard to the claims experience of those individuals, and their dependents or any health status-related factor relating to such individuals, and dependents.

An issuer that denies coverage to any individual may not offer coverage in the individual market before the later of the following dates:

(1) The 181st day after the date the issuer denies coverage;

(2) The date the issuer demonstrates to the director that the issuer has sufficient financial reserves to underwrite additional coverage.

Nothing in this section limits an issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage. Coverage offered after the 180-day period specified in this section is subject to the requirements of this section and § 20:06:55:42. The ability to offer or renew coverage as specified by this section and § 20:06:55:42 is subject to all applicable service area requirements and restrictions.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:59. Open enrollment. After December 31, 2013 a health insurance issuer must provide an initial open enrollment period and annual open enrollment periods outside the individual Exchange, during which qualified individuals may enroll in a non-grandfathered plan or enrollees may change plans. A health insurance issuer may restrict enrollment to a qualified

individual or an enrollee to change plans during the initial open enrollment period, the annual open enrollment period, or a special enrollment period for which the qualified individual or enrollee has been determined eligible. The restrictions relative to enrollment outside the annual enrollment period do not apply to plans offered outside the individual market Exchange. An individual is not qualified unless that individual resides in this state.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:60. Initial open enrollment period. The initial open enrollment period in the individual market outside the individual market Exchange begins October 1, 2013 and extends through March 31, 2014. The effective coverage dates for the initial open enrollment period are as follows:

(1) For a person enrolling on or before December 15, 2013, the issuer must make the coverage effective on January 1, 2014;

(2) For a person enrolling between the first and fifteenth day of January 1, 2014 to March 15, 2014, the issuer must make coverage effective on the first day of the following month; and

(3) For a person enrolling between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the issuer must make coverage effective on the first day of the second following month.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:61. Annual open enrollment period. For benefit years beginning on or after January 1, 2015, the annual open enrollment period for the individual market outside the individual market Exchange begins October 15 and extends through December 7 of the preceding calendar year.

Coverage is effective as of the first day of the following benefit year for a qualified individual who selects a plan selection during the annual open enrollment period.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:62. Special enrollment period effective dates. After December 31, 2013 a health insurance issuer must provide special enrollment periods consistent with this section outside the Exchange, during which qualified individuals and enrollees may enroll in nongrandfathered health plans or change enrollment from one plan to another. Once a qualified

individual is determined eligible for a special enrollment period, the health insurance issuer must ensure that the qualified individual's effective date of coverage is:

(1) On the first day of the following month for all nongrandfathered health plan selections made by the 22nd of the previous month,

(2) On either the first day of the following month or the first day of the second following month for all nongrandfathered plan selections made between the 23rd and last day of a given month, or

(3) In the case of birth, adoption or placement for adoption effective on the date of birth, adoption, or placement for adoption.

Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a nongrandfathered health plan.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:63. Waiting period. After December 31, 2013 a health insurance issuer may for any individual applying for coverage outside of an insurance Exchange and outside of an open enrollment period that has not had creditable coverage within the prior 63 days, require a waiting period of not more than 90 days from the date of application until coverage is effective. The waiting period between the date of application and the effective date also

applies to individuals who wish to significantly increase benefits by choosing an alternative plan. This section applies to all applications received after March 31, 2014 in the individual market outside the Exchange.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:64. Enrollment in catastrophic plans. A health plan is a catastrophic plan if it meets the following conditions:

(1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market;

(2) Does not provide a bronze, silver, gold, or platinum level of coverage described in § 20:06:56:11;

(3) Provides coverage of the essential health benefits under § 20:06:56:03 once the annual limitation on cost sharing is reached;

(4) Provides coverage for at least three primary care visits per year before reaching the deductible; and

(5) Covers only individuals who meet either of the following conditions:

(a) Have not attained the age of 30 prior to the first day of the plan year;

(b) Have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of PPACA as defined in § 20:06:55:32.

A catastrophic plan may not impose any cost-sharing requirements, such as a copayment, coinsurance, or deductible, for preventive services, in accordance with § 20:06:56:03. For other than self-only coverage, each individual enrolled must meet the requirements.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:65. Student health insurance coverage. Student health insurance coverage is considered to be available only through a bona fide association. A health insurance issuer that offers student health insurance coverage is not required to accept persons who are not students or dependents of students in such coverage.

A health insurance issuer that offers student health insurance coverage is not required to renew or continue coverage for individuals who are no longer students or dependents of students.

This section applies to any non-grandfathered student health coverage issued or renewed after December 31, 2013.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:66. Clinical trial. After December 31, 2013 a health insurance issuer that offers a health benefit plan providing health insurance coverage individual market in this state may not:

(1) Deny participation by a qualified individual in an approved clinical trial;

(2) Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or

(3) Discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:67. Nonrenewal of coverage. After December 31, 2013 a health insurance issuer offering health insurance coverage in the individual market is required to renew or continue in force the coverage at the option of the individual. An issuer may nonrenew or discontinue health insurance coverage offered in the individual market based only on the occurrence of one or more of the following:

(1) Nonpayment of premiums. The plan sponsor or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements;

(2) Fraud. The plan sponsor or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;

(3) Termination of plan. The issuer is ceasing to offer coverage in the market in accordance with § 20:06:39:58.

(4) Enrollees' movement outside service area. For network plans, there is no longer any enrollee under the plan who lives, resides, or works in the service area of the issuer; and

(5) Association membership ceases. For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the bona fide association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

This section does not apply to grandfathered plans.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:68. Discontinuing a particular product. After December 31, 2013 in any case in which a health insurance issuer elects to discontinue offering a particular product in the individual market, that product may only be discontinued by the issuer if the following occurs:

(1) The issuer provides notice in writing to each individual provided that particular product in that market covered under such coverage of the discontinuation at least 90 calendar days before the date the coverage will be discontinued;

(2) The issuer offers to each individualprovided that particular product the option, on a guaranteed issue basis, to purchase all health insurance coverage currently being offered by the issuer to an individual health insurance coverage; and

(3) In exercising the option to discontinue that product and in offering the option of coverage, the issuer acts uniformly without regard to the claims experience of those individuals, or any health status-related factor relating to any participant or beneficiary covered or new participant or beneficiary who may become eligible for such coverage.

This section does not apply to grandfathered plans.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:69. Discontinuing all coverage. After December 31, 2013 an issuer may elect to discontinue offering all health insurance coverage in the individual market, or all markets, in a state in accordance with applicable state law only if the issuer meets all of the following conditions:

(1) The issuer provides notice in writing to the director and to each individual covered under the discontinued coverage at least 180 calendar days prior to the date the coverage will be discontinued; and

(2) All health insurance policies issued or delivered for issuance by the issuer in the state in the applicable market or markets are discontinued and not renewed; and

An issuer that elects to discontinue offering all health insurance coverage in a market or markets in a state may not issue coverage in the applicable market or markets in the state for a period of five years beginning on the date of discontinuation for the last coverage discontinued.

This section does not apply to grandfathered plans.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:70. Special enrollment periods for marriage, birth, and adoption. After December 31, 2013 a special enrollment period occurs for the individual, the individual's spouse, and the individual's dependents if the following conditions are met:

(1) A group health benefit plan makes coverage available with respect to a dependent of an individual;

(2) The individual is an employee; and

(3) The individual becomes married or a child becomes a new dependent as a result of marriage, birth, adoption, or placement for adoption;

The special enrollment period must be at least 60 days in length and must begin 30 days after the qualifying event. If coverage required pursuant to this section is applied for, the effective date for coverage in the case of a marriage may be no later than the first day of the first

calendar month after the date the completed request is received by the plan or, in the case of a dependent, the date of birth or the start of the adoption bonding period.

This section does not apply to grandfathered plans.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:71. Special enrollment triggers. After December 31, 2013 a health insurance issuer offering health insurance coverage in the individual market outside the Exchange must allow for an individual or dependent to enroll or change from one plan to another as a result of the following qualifying events:

(1) The death of the covered individual;

(2) The termination of individual's employer coverage other than by reason of gross misconduct, or reduction of hours of the covered employees spouse,

(3) The divorce or legal separation;

(4) Individual becoming entitled to a benefits under XVII of the Social Security Act;

(5) Dependent child ceasing to be dependent child;

(6) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986 with respect to the employer from whose employment the covered individual retired at any time;

(7) An individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(8) An individual, who was not previously a citizen, national, or lawfully present individual gains such status; and,

(9) A qualified individual or enrollee gains access to nongrandfathered health plan as a result of a permanent move.

This section does not apply to grandfathered plans

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:72. Preexisting condition exclusion and waiting period prohibited. No health insurance issuer offering an individual health benefit plan may impose any preexisting condition exclusion or preexisting condition waiting period with respect to such coverage.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:39:73. Applicability. Effective January 1, 2014 §§ 20:06:39:03, 20:06:39:05, 20:06:39:07, 20:06:39:10, 20:06:39:19, 20:06:39:20, 20:06:39:20.05, and 20:06:39:30, only apply to grandfathered plans.

Sections 20:06:39:04, 20:06:39:06, 20:06:39:08, and 20:06:39:34 are repealed effective January 1, 2014.

Sections 20:06:39:04.01, 20:06:39:06.01, 20:06:39:08.01, and 20:06:39:34.01 are effective January 1, 2014.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

DEPARTMENT OF ~~REVENUE~~ LABOR AND REGULATION

DIVISION OF INSURANCE

EXAMPLE OF CERTIFICATE OF INDIVIDUAL HEALTH INSURANCE COVERAGE

Chapter 20:06:39

APPENDIX A

SEE: § 20:06:39:04

Source: 24 SDR 35, effective September 29, 1997.

CERTIFICATE OF INDIVIDUAL HEALTH INSURANCE COVERAGE

IMPORTANT - This certificate provides evidence of your health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for medical conditions you have before you enroll, if medical advice, diagnosis, care, or treatment is recommended or received for the condition during the 6 months before you enroll in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to establish your right to buy coverage for yourself or your family, ~~with no exclusion for previous medical conditions, if you are not covered under a group health plan~~.

1. Date of this certificate: _____.

2. Name of policyholder: _____.

3. Identification number of policyholder: _____.

4. Name of any dependents to whom this certificate applies: _____

   _____.

5. Name, address, and telephone number of issuer responsible for providing this certificate: _____

   _____

   _____

6. For further information, call: _____.

7. If all individual(s) identified in items 2 and 4 have at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ___ and skip items 8 and 9.

8. Date coverage began: _____.

9. Date that a substantially completed application was received from the policyholder: _____

10. Date coverage ended: _____ (or check here if coverage is continuing as of the date of this certificate: _____).

Note: Separate certificates will be furnished if information is not identical for the policyholder and each dependent.

DEPARTMENT OF ~~REVENUE~~ LABOR AND REGULATION

DIVISION OF INSURANCE

NOTICE OF RESEARCH EXCEPTION

Chapter 20:06:39

APPENDIX B

SEE: § 20:06:39:47

Source: 37 SDR 47, effective September 20, 2010

Notice of Research Exception

PART I: Entity Classification and Identification

1. Date of submission: _____

2. Specify whether the entity claiming the research exception is:

(A) ☐ A group health plan (plan); or

(B) ☐ A health insurance issuer (issuer).

3. If the entity is a plan (as designated in Box 2A), is the plan:

(A) ☐ A plan subject to Part 7 of Title I of ERISA;

(B) ☐ A church plan; or

(C) ☐ A nonfederal governmental plan.

4. If the entity is an issuer (as designated in Box 2B), is the issuer claiming the exception in connection with the provision of:

(A) ☐ Group health insurance coverage only;

(B) ☐ Individual health insurance coverage only; or

(C) ☐ Both group and individual health insurance coverage.

5a. Name and address of the entity claiming the exception:

_____

_____

_____

5b. Telephone number of entity claiming the exception:

_____

5c. Employer Identification Number (EIN) of the entity claiming the exception:

_____

5d. If the entity is a plan (as designated in Box 2A), specify plan number:

_____

PART II: Research Project Information

6. Title of the research project:

_____

7. Name of the principal investigator:

_____

8. Research project number (if available):

_____

PART III: Attestation of Compliance with the Requirements of the Research Exception

With respect to the research project described in Part II, I attest that the following is true:

(i) The research complies with 45 CFR part 46 or equivalent federal regulations and applicable state or local law or regulations for the protection of human subjects in

research; (ii) each request of a participant or beneficiary (or in the case of a minor child, the legal guardian of such beneficiary) to undergo genetic testing as part of the research will be made in writing and clearly indicate that compliance with the request is voluntary and that noncompliance will have no effect on eligibility for benefits or premium or contribution amounts; and (iii) no genetic information collected or acquired through this research will be used for underwriting purposes.

Under penalty of perjury, I declare that I have examined this notice, including any accompanying attachments, and to the best of my knowledge and belief, it is true and correct. Under penalty of perjury, I also declare that this notice is complete.

Signature: _____ Date: _____

Type or print name, address, and telephone number:

CHAPTER 20:06:40

EMPLOYER PLANS

Section

20:06:40:06	Affiliation periods for health maintenance organizations.
20:06:40:07	Repealed.
20:06:40:08	Standards for determining when a condition is preexisting.
20:06:40:09	~~Notification of determinations on preexisting waiting periods and appeal and reconsideration procedures.~~ Repealed
20:06:40:10	~~Creditable coverage and preexisting waiting periods for newborn and adopted children.~~ Repealed
20:06:40:11	~~Renewal rights under association plans.~~Repealed.
20:06:40:12	~~Health benefit arrangement defined.~~ Repealed.
20:06:40:13	Public health plan defined.
20:06:40:14	~~Carrier defined.~~ Repealed.
20:06:40:15	~~Permissible methods of crediting coverage -- Alternative method prohibited.~~ Repealed.
20:06:40:16	Notice describing plan's special enrollment required.
20:06:40:17	Group health plans to offer breast reconstruction options after covered mastectomy.

20:06:40:29	Definitions.
20:06:40:30	Group rating based on health factors.
20:06:40:31	No group-based discrimination based on genetic information.
20:06:40:32	Limitation on requesting or requiring genetic testing.
20:06:40:33	Exceptions to requiring genetic testing.
20:06:40:34	Research exception.
20:06:40:35	Prohibitions on collection of genetic information for underwriting purposes.
20:06:40:36	Medical appropriateness.
20:06:40:37	Collection of genetic information prior to or in connection with enrollment.
20:06:40:38	Incidental collection exception.
20:06:40:39	General exception for certain small group health plans.
20:06:40:40	Applicability to excepted benefits.
20:06:40:41	Effective date.
20:06:40:42	Definitions.

20:06:40:43	Parity requirements with respect to aggregate lifetime and annual dollar limits.
20:06:40:44	Plan with no limit or limits on less than one-third of all medical or surgical benefits.
20:06:40:45	Plan with a limit on at least two-thirds of all medical or surgical benefits.
20:06:40:46	Determining one-third and two-thirds of all medical or surgical benefits.
20:06:40:47	Plan not described in sections 20:06:40:44 or 20:06:40:45 of this chapter.
20:06:40:48	Parity requirements with respect to financial requirements and treatment limitations -- Clarification of classification of benefits.
20:06:40:49	Parity requirements with respect to financial requirements and treatment limitations -- Clarification of type of financial requirement or treatment limitation.
20:06:40:50	Parity requirements with respect to financial requirements and treatment limitations -- Clarification of level of a type of financial requirement or treatment limitation.

20:06:40:51	Parity requirements with respect to financial requirements and treatment limitations -- Clarification of coverage unit.
20:06:40:52	General parity requirement.
20:06:40:53	Classifications of benefits used for applying rates.
20:06:40:54	Application to out-of-network providers.
20:06:40:55	Financial requirements and quantitative treatment limitations -- Determining substantially all.
20:06:40:56	Financial requirements and quantitative treatment limitations -- Determining predominant.
20:06:40:57	Financial requirements and quantitative treatment limitations -- Determining portion based on plan payments.
20:06:40:58	Financial requirements and quantitative treatment limitations -- Determining clarifications for certain threshold requirements.
20:06:40:59	Application to different coverage units.
20:06:40:60	Special rule for multi-tiered prescription drug benefits.
20:06:40:61	No separate cumulative financial requirements or cumulative quantitative treatment limitations.
20:06:40:62	Nonquantitative treatment limitations.

20:06:40:63	Illustrative list of nonquantitative treatment limitations.
20:06:40:64	Exemptions.
20:06:40:65	Availability of plan information -- Criteria for medical necessity determinations.
20:06:40:66	Availability of plan information -- Reasons for denial.
20:06:40:67	Applicability -- Group health plans.
20:06:40:68	Applicability -- Health insurance issuers.
20:06:40:69	Scope.
20:06:40:70	Small employer exemption.
20:06:40:71	Determining employer size.
20:06:40:72	Sale of nonparity health insurance coverage.
20:06:40:73	Special effective date for certain collective-bargained plans.
20:06:40:74	Establishment of sub-classifications for determining parity for outpatient benefits.
20:06:40:75	Definitions.
20:06:40:76	Guaranteed issue.
20:06:40:77	Disclosure requirements

20:06:40:78 Guaranteed availability of coverage in the group market.

20:06:40:79 Denial of coverage.

20:06:40:80 Special enrollment period effective dates.

20:06:40:81 Special enrollment triggers.

20:06:40:82 Nonrenew or discontinuance of coverage.

20:06:40:83 Discontinuing a particular product.

20:06:40:84 Discontinuing all coverage.

20:06:40:85 Exception for uniform modification of coverage.

20:06:40:86 Preexisting condition exclusion and waiting period prohibited.

20:06:40:87 Clinical trial.

20:06:40:87 Full-time equivalents treated as full-time employees.

20:06:40:89 Applicability.

Appendix A ~~Example of Certificate of Prior Group Health Plan Coverage.~~ Repealed

Appendix B Notice of Research Exception.

20:06:40:01. Waiting periods, affiliation periods, and applications relating to breaks in coverage. ~~Waiting periods and delays in the provision of coverage by the employer do not count toward the maximum break in coverage of 63 days. An affiliation period may not be used in counting toward the maximum break in coverage. Any waiting period for a new employee to be eligible to enroll in the employer's health benefit plan counts toward the satisfaction of any waiting period for preexisting conditions contained in that health benefit plan. For employees~~

~~who have a waiting period after employment to qualify for coverage under the employer's health benefit plan, the enrollment date is the date of employment. For late enrollees, the enrollment date is the date coverage begins. The time period after substantial completion of an application for coverage does not count toward the maximum 63-day break in coverage whether or not coverage is ultimately obtained. If an individual withdraws a pending application or fails to fully complete a pending application after a reasonable period of time, the carrier may count the period of time since substantial completion of the application toward the maximum break in coverage of 63 days.~~ Repealed January 1, 2014.

Source: 24 SDR 35, effective September 19, 1997.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-43, 58-18-44, 58-18-45, 58-18-48, 58-18-79.~~

20:06:40:01.01. Waiting periods and affiliation periods relating to breaks in coverage. Waiting periods and delays in the provision of coverage by the employer do not count toward the maximum break in coverage of 63 days for purposes of individual market enrollment. An affiliation period may not be used in counting toward the maximum break in coverage.. For employees who have a waiting period after employment to qualify for coverage under the employer's health benefit plan, the enrollment date is the date of employment. For late enrollees, the enrollment date is the date coverage begins

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-43, 58-18-44, 58-18-45, 58-18-48, 58-18-79.

20:06:40:02. Short-term, limited duration policies. Creditable coverage includes short-term limited duration policies. Short-term, limited duration insurance means health insurance coverage provided under a contract with a ~~carrier~~ health insurance issuer that has an expiration date specified in the contract that is within 12 months of the date the contract becomes effective, including any extensions that may be elected by the policyholder without the ~~carrier's~~ health insurance issuers' consent.

Source: 24 SDR 35, effective September 29, 1997.

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-44, 58-18-79.

20:06:40:03. Certificates required upon losing coverage. ~~A carrier must automatically provide a certificate containing language that is substantially similar to the language contained in Appendix A at the end of this chapter to any individual losing coverage or qualifying for continuation under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C.S. § 1163, as in effect July 1, 1997, or SDCL chapter 58-18. At any time within 24 months after coverage ceases, a carrier must also provide additional certificates pursuant to requests by or on behalf of an individual. Each certificate must be provided in a reasonable and prompt fashion. A separate fee may not be charged for the provision of a certificate, but the cost of this service may be factored into the policy premium.~~

~~After July 1, 1998, a carrier must provide certificates as required in this section for dependents as well as the individual to whom the coverage was issued. Before July 1, 1998, a carrier may satisfy the requirement for certificates identifying coverage for dependents by providing the name of the policyholder and specifying that family coverage is in force. Before July 1, 1998, if the carrier is requested to provide a certificate for a dependent, the carrier must make reasonable efforts to obtain and provide the name of the dependent.~~

~~If a carrier provides coverage in connection with another type of creditable coverage, the carrier must provide a certificate as required by this section. A carrier may, for an individual with at least 12 months of creditable coverage without a break in coverage exceeding 63 days, simply certify that the individual has 12 months of creditable coverage.~~Repealed January 1, 2014.

Source: 24 SDR 35, effective September 29, 1997.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-11-1, 58-18-44, 58-18-45, 58-18-48, 58-18-79, 58-33-36.~~

20:06:40:03.01. Certificates required upon losing coverage. A health insurance issuer must automatically provide a certificate to any individual losing coverage or qualifying for continuation under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C.S. § 1163, as in effect July 1, 1997, or SDCL chapter 58-18. At any time within 24 months after coverage ceases, a health insurance issuer must also provide additional certificates pursuant to requests by or on behalf of an individual. Each certificate must be provided in a reasonable and

prompt fashion. A separate fee may not be charged for the provision of a certificate, but the cost of this service may be factored into the policy premium.

After July 1, 1998, a health insurance issuer must provide certificates as required in this section for dependents as well as the individual to whom the coverage was issued. Before July 1, 1998, a health insurance issuer may satisfy the requirement for certificates identifying coverage for dependents by providing the name of the policyholder and specifying that family coverage is in force. Before July 1, 1998, if the health insurance issuer is requested to provide a certificate for a dependent, the health insurance issuer must make reasonable efforts to obtain and provide the name of the dependent.

If a health insurance issuer provides coverage in connection with another type of creditable coverage, the health insurance issuer must provide a certificate as required by this section. A health insurance issuer may, for an individual with at least 12 months of creditable coverage without a break in coverage exceeding 63 days, simply certify that the individual has 12 months of creditable coverage.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-11-1, 58-18-44, 58-18-45, 58-18-48, 58-18-79, 58-33-36.

20:06:40:05. Special enrollment periods for marriage, birth, and adoption. A special enrollment period occurs for the individual, the individual's spouse, and the individual's dependents if the following conditions are met:

(1) A group health benefit plan makes coverage available with respect to a dependent of an individual;

(2) The individual is an employee; and

(3) The individual becomes married or a child becomes a new dependent as a result of marriage, birth, adoption, or placement for adoption.

The special enrollment period must be at least 31 days in length and must begin 30 days after the qualifying event. If coverage required pursuant to this section is applied for, the effective date for coverage in the case of a marriage may be no later than the first day of the first calendar month after the date the completed request is received by the plan or, in the case of a dependent, the date of birth or the start of the adoption bonding period.

Source: 24 SDR 35, effective September 29, 1997; 28 SDR 157, effective May 19, 2002; 30 SDR 189, effective June 7, 2004.

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-43, 58-18-44, 58-18-45, 58-18-48, 58-18-79.

20:06:40:09. Notification of determinations on preexisting waiting periods and appeal and reconsideration procedures. ~~Within a reasonable time following the receipt of the certificate or other evidence of coverage, a plan or carrier must determine the length of any preexisting condition waiting period that applies to the individual and notify the individual of its determination. Whether a determination and notification are made within a reasonable period of time depends upon the relevant facts and circumstances, including whether the application of the preexisting condition waiting period would prevent access to urgent medical services. The plan or carrier is required to notify the individual, however, only if, after considering the evidence, it has determined that a preexisting condition waiting period will be imposed on the individual. The basis of the determination, including the source and substance of any information on which the plan or carrier relied, must be included in the notification. The notification must also explain the plan's appeal procedures and the opportunity of the individual to present additional evidence.~~

~~The plan or carrier may reconsider and modify its initial determination if it determines that the individual did not have the claimed creditable coverage. In this circumstance, the plan or carrier must notify the individual of the reconsideration and, until a final determination is made, must act in accordance with its initial determination for purposes of approving medical services.~~ Repealed.

Source: 24 SDR 35, effective September 29, 1997.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-43, 58-18-45, 58-18-48, 58-18-79.~~

20:06:40:10. Creditable coverage and preexisting waiting periods for newborn and adopted children. ~~A child who was covered as a dependent within 31 days of the date of birth under the policy of a parent, or within 31 days after the start of the adoption bonding period under the policy of a prospective parent in the case of a child who has been placed for adoption, is not subject to the creditable coverage requirement of 12 months and qualifies as having 12 months of creditable coverage pursuant to SDCL 58-18-44 if any creditable coverage has been in force within the preceding 63 days. Waiting periods for preexisting conditions may not be imposed on children who meet the requirements of this section~~. Repealed.

Source: 24 SDR 35, effective September 29, 1997.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-32, 58-18-44, 58-18-45, 58-18-79.~~

20:06:40:11. Renewal rights under association plans. ~~All employers covered under an association plan have the right to renew the coverage they received if the association ceases to serve its members, regardless of the reason.~~ Repealed.

Source: 23 SDR 35, effective September 29, 1997.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-46, 58-18-79.~~

20:06:40:12. Health benefit arrangement defined. ~~For purposes of SDCL 58-18-44, a health benefit arrangement includes an arrangement by a state, the membership composition of which is specified by the state, which is established and maintained primarily to provide health insurance coverage for individuals who are residents of the state and who, because of the existence or history of a medical condition, are unable to acquire medical care coverage for a condition through insurance or from an HMO or are able to acquire coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.~~ Repealed.

Source: 24 SDR 35, effective September 29, 1997.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-44.~~

20:06:40:14. Carrier defined. ~~For purposes of this chapter, the term "carrier" includes any plan of insurance described in SDCL 58-18-51.1 or the administrator of such a plan.~~Repealed.

Source: 24 SDR 35, effective September 29, 1997.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-48, 58-18-79.~~

20:06:40:15. Permissible methods of crediting coverage -- Alternative method prohibited. ~~A carrier or plan may not use any other methods of crediting prior coverage for~~

~~purposes of applying any preexisting waiting period other than those expressly permitted in SDCL chapter 58-18 and may not use the alternative method of crediting coverage in 45 C.F.R. § 146.113(c) as published on 62 Fed. Reg. 16,960-16,962 (April 8, 1997).~~ Repealed.

Source: 24 SDR 35, effective September 29, 1997.

~~**General Authority:** SDCL 58-18-79.~~

~~**Law Implemented:** SDCL 58-18-48, 58-18-79.~~

20:06:40:16. Notice describing plan's special enrollment required. By the time an employee is offered the opportunity to enroll in a group health plan, the plan must provide the employee with a written notice containing a description of the plan's special enrollment rules. A plan or ~~carrier~~ health insurance issuer may use the following model notice:

"If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you request enrollment within 30 after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents if you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption."

Source: 24 SDR 35, effective September 29, 1997.

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-48, 58-18-79.

20:06:40:18. Claims experience defined. For employers with ~~two~~ one to fifty enrolled employees, claims experience ~~shall mean~~ is the amount of paid claims for the employer and the time period that the claims were incurred and paid. For employers with fifty-one or more enrolled employees, claims experience ~~shall mean~~ is the amount of paid claims for the employer, the time period that the claims were incurred and paid, and a listing of claims of $10,000 or more for any person covered by the employer in a manner consistent with applicable state and federal laws. A paid claim is the actual payment or settlement amount paid by the ~~health carrier~~ health insurance issuer and excludes all noncovered services, provider discounts, and member liability amounts. The change from one to two, regarding the size of an employer is effective after December 31, 2013.

Source: 31 SDR 21, effective August 23, 2004.

General Authority: SDCL 58-18-79(1).

Law Implemented: SDCL 58-18-82.

20:06:40:19. Additional continuation election. ~~An individual who qualifies as an assistance eligible individual pursuant to the American Recovery and Reinvestment Act of 2009 and failed to elect continuation upon the qualifying event may elect special assisted continuation of coverage as provided in the American Recovery and Reinvestment Act of 2009.~~

~~The insurer shall, no later than April 18, 2009, provide the additional notice, either directly to the eligible individual or indirectly to the eligible individual through the employer, of the right to elect coverage pursuant to this section. An assistance eligible individual electing continuation pursuant to this section must make the election to the insurer within 3030 following receipt of the notice.~~ Repealed.

Source: 35 SDR 234, effective April 2, 2009; 35 SDR 306, effective July 1, 2009.

~~**General Authority:** SDCL 58-18-79(16).~~

~~**Law Implemented:** SDCL 58-18-7, 58-18-7.5.~~

20:06:40:20. Period of special continuation. ~~Special assisted continuation of coverage elected pursuant to § 20:06:40:19 commences with the first period of assisted continuation of coverage beginning after February 16, 2009, and extends for the period as though the election had been made pursuant to SDCL 58-18-7.5 to 58-18-7.20, inclusive, upon the date of the qualifying event.~~ Repealed.

Source: 34 SDR 234, effective April 2, 2009; 35 SDR 306, effective July 1, 2009.

~~**General Authority:** SDCL 58-18-79(16).~~

~~**Law Implemented:** SDCL 58-18-7, 58-18-7.5.~~

20:06:40:21. Treatment of special continuation. ~~Any person electing continuation pursuant to § 20:06:40:19 is considered as having continuing coverage and is not subject to a preexisting condition exclusion.~~ Repealed.

Source: 35 SDR 234, effective April 2, 2009; 35 SDR 306, effective July 1, 2009.

~~**General Authority:** SDCL 58-18-79(16).~~

~~**Law Implemented:** SDCL 58-18-7, 58-18-7.5.~~

20:06:40:22. Premium subsidy. ~~An individual eligible for assisted continuation of coverage who elects such coverage is entitled to the premium subsidy provided in the American Recovery and Reinvestment Act of 2009 so long as the individual meets the requirements for special assisted continuation coverage pursuant to the terms of the American Recovery and Reinvestment Act of 2009.~~ Repealed.

20:06:40:24. Dependent coverage. ~~Any health carrier~~ A health insurance issuer issuing a health benefit plan that provides dependent coverage for any qualifying child may not terminate coverage due to a medically necessary leave of absence for a period of twelve months after the first day of leave or the date on which such coverage would otherwise terminate under the terms of the plan, whichever is earlier. A qualifying child whose benefits are continued under this section is entitled to the same benefits as if the qualifying child continued to be a covered student and was not on a medically necessary leave of absence.

The health benefit plan must receive written certification of the medically necessary leave of absence by a treating physician of the qualifying child that states that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.

Source: 36 SDR 96, effective December 9, 2009.

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79.

20:06:40:25. Notification. Any health insurance ~~carrier~~ issuer providing health insurance coverage in connection with a group health plan shall include, with any notice regarding a requirement for certification of student status for coverage under the plan, a description of the terms of § 20:06:40:24 for continued coverage during any medically necessary leave of absence. Such description shall be in language that is understandable to the typical plan participant.

Source: 36 SDR 96, effective December 9, 2009.

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79.

20:06:40:75. Definitions.

(1) ‘‘Employer contribution rule, ’’ a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries;

(2) ‘‘Group participation rule’’ a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer;

(3) “Health insurance issuer,” any person that provides health insurance in this state including an insurance company, a prepaid hospital, or similar plan, a health maintenance organization, a multiple employer welfare arrangement, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. A health insurance issuer does not include a person providing only excepted benefits; and

(4) “Small employer,” in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

Source:

General Authority: SDCL 58-18B-36(7)(8)(11), 58-18B-46.

Law Implemented: SDCL 58-18B-36, 58-18B-37, 58-18B-46.

20:06:40:76. Guaranteed issue. A small employer health insurance issuer must offer each of its small employer plans to any eligible small employer on a guaranteed issue basis without medical underwriting. A small employer health insurance issuer may use reasonable contribution and participation requirements that are consistent between small employers and which do not relate to the health status or health history of the employees or dependents of a small employer or the

risk characteristics of the small employer as a whole. A health insurance issuer may limit the availability of health insurance coverage offered in the small group market to an annual enrollment period that begins November 15 and extends through December 15 of each year if a plan sponsor is unable to comply with a material plan provision relating to employer contribution or group participation rules as required by SDCL 58-18B-24 to 58-18B-26, inclusive. With respect to coverage in the small group market, and in the large group market if such coverage is offered in a Small Business Health Options Program (SHOP) as defined in § 20:06:55:32 in this state, coverage must become effective consistent with the dates described in 45 CFR §155.725(h)

Source:

General Authority: SDCL 58-18B-36(7)(8)(11), 58-18B-46.

Law Implemented: SDCL 58-18B-36, 58-18B-37, 58-18B-46.

20:06:40:77. Disclosure requirements. In its sales and solicitation materials, a health insurance issuer must disclose that the following specific materials are available upon request:

(1) A statement detailing the health insurance issuer's right to change premium rates and the factors that may affect changes in premium rates;

(2) A notice detailing renewability of coverage;

(3) A description of the geographic area served by the Health Maintenance Organization; and

(4) A statement of the benefits and premiums available for all health insurance coverage for which the employer is qualified under permitted contribution and participation requirements.

This section does not require the disclosure of proprietary information or trade secrets. The disclosure information provided must be in a format that is understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. Examples of reasonable information that may be provided pursuant to this section include rating schedules for each product for which more than one rate applies and maps of the service areas or lists of counties served by a network plan.

Source:

General Authority: SDCL 58-18B-36(8), (9), 58-18B-46.

Law Implemented: SDCL 58-18B-6, 58-18B-36, 58-18B-46.

20:06:40:78. Guaranteed availability of coverage in the group market. A health insurance issuer that offers health insurance coverage in the group market in this state must offer to any individual or employer in the state all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products.

A health insurance issuer offering health insurance coverage in the small group market must ensure that such coverage includes the essential health benefits package as defined in § 20:06:56:03 effective for plan or policy years beginning after December 31, 2013.

Source:

General Authority: SDCL 58-18-79

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:79. Denial of coverage. A health insurance issuer may deny health insurance coverage in the group market if the issuer demonstrates to the director the following:

(1) The health insurance issuer does not have the financial reserves necessary to underwrite additional coverage; and

(2) The health insurance issuer is applying the denial uniformly to all employers or individuals in the group or individual market, as applicable, in this state without regard to the claims experience of those individuals, employers, and their employees and their employees' dependents or any health status-related factor relating to such individuals, employees, and dependents.

An issuer that denies group health insurance coverage to any employer may not offer coverage in the group market in this state before the later of the following dates:

(1) The 181st day after the date the issuer denies coverage, or

(2) The date the issuer demonstrates to the applicable state authority that the issuer has sufficient financial reserves to underwrite additional coverage.

Nothing in this section limits the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage. Coverage offered after the 180-day period specified in this section is subject to the requirements of this section and § 20:06:55:42. The ability to offer or renew coverage as specified by this section and § 20:06:55:42 is subject to all applicable service area requirements and restrictions.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:80. Special enrollment period effective dates. A health insurance issuer must provide special enrollment periods consistent with this section, during which qualified individuals and enrollees may enroll in plans or change enrollment from one nongrandfathered health plan to another. Once a qualified individual is determined eligible for a special enrollment period, the health insurance issuer must ensure that the qualified individual's effective date of coverage is:

(1) On the first day of the following month for all nongrandfathered health plan selections made by the 22nd of the previous month,

(2) On either the first day of the following month or the first day of the second following month for all nongrandfathered health plan selections made between the 23rd and last day of a given month, or

(3) In the case of birth, adoption or placement for adoption effective on the date of birth, adoption, or placement for adoption.

Unless specifically stated otherwise herein, a qualified individual or enrollee has 30 days from the date of a triggering event to select a plan.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:81. Special enrollment triggers. A health insurance issuer offering health insurance coverage in the group market and SHOP Exchange as defined in § 20:06:55:32 must allow for an individual to enroll or change from one nongrandfathered health plan to another as a result of the following triggers:

(1) The death of the covered individual;

(2) The termination of individual's employer coverage other than by reason of gross misconduct, or reduction of hours of the covered employees spouse,

(3) The divorce or legal separation;

(4) Individual becoming entitled to a benefits under XVII of the Social Security Act;

(5) Dependent child ceasing to be dependent child;

(6) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986 with respect to the employer from whose employment the covered individual retired at any time;

(7) An individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(8) An individual, who was not previously a citizen, national, or lawfully present individual gains such status; and,

(9) A qualified individual or enrollee gains access to nongrandfathered health plan as a result of a permanent move.

This section does not apply to grandfathered plans

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:82. Nonrenew or discontinuance of coverage. A health insurance issuer offering health insurance coverage in the group market is required to renew or continue in force the coverage at the option of the plan sponsor or the employer, as applicable. An issuer may nonrenew or discontinue health insurance coverage offered in the group market based only on one or more of the following:

(1) Nonpayment of premiums. The plan sponsor or employer, as applicable, fails to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements;

(2) Fraud. The plan sponsor or employer as applicable, performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact in connection with the coverage;

(3) Violation of participation or contribution rules. In the case of group health insurance coverage, the plan sponsor has fails to comply with a material plan provision relating to employer contribution or group participation rules;

(4) Termination of plan. The issuer ceases to offer coverage in the market;

(5) Enrollees' movement outside service area. For network plans, there is no longer any enrollee under the plan who lives, resides, or works in the service area of the issuer or in the area for which the issuer is authorized to do business; and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under 45 CFR § 147.104(c)(1)(i).

(6) Association membership ceases. For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the bona fide association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:83. Discontinuing a particular product. If an issuer discontinues offering a particular product in the group market, that product may be discontinued by the issuer in the applicable market only if the following occurs:

(1) The issuer provides notice in writing to each plan sponsor, as applicable, provided that particular product in that market and to all participants and beneficiaries covered under such coverage of the discontinuation at least 90 calendar days before the date the coverage will be discontinued;

(2) The issuer offers to each plan sponsor, as applicable, provided that particular product the option, on a guaranteed issue basis, to purchase all or, in the case of the large group market, any other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in that market, and;

(3) In exercising the option to discontinue that product and in offering the option of coverage, the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or

beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:84. Discontinuing all coverage. An issuer may elect to discontinue offering all health insurance coverage in the group market, or all markets, in a state in accordance with applicable state law only if the issuer meets all of the following conditions:

(1) The issuer provides notice in writing to the applicable state authority and to each plan sponsor or individual, as applicable, and all participants and beneficiaries covered under the coverage of the discontinuation at least 180 calendar days prior to the date the coverage will be discontinued;

(2) All health insurance policies issued or delivered for issuance in the state in the applicable market or markets are discontinued and not renewed; and

(3) An issuer that elects to discontinue offering all health insurance coverage in a market or markets may not issue coverage in the applicable market or markets and state involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:85. Exception for uniform modification of coverage. Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the following:

(1) Large group market, and;

(2) Small group market if, for coverage available in this market other than only through one or more bona fide associations, the modification is consistent with state law and is effective uniformly among group health plans with that product.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:86. Preexisting condition exclusion and waiting period prohibited. A health insurance issuer offering a group health benefit plans may not impose any preexisting condition exclusion or preexisting condition waiting period with respect to such coverage.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:87. Clinical trial. A health insurance issuer that offers a health benefit plan providing group market health insurance coverage in this state may not:

(1) Deny participation by a qualified individual in an approved clinical trial;

(2) Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or

(3) Discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:88. Full-time equivalents treated as full-time employees. Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

20:06:40:89. Applicability. The provisions §§ 20:06:40:75 to 20:06:40:88 apply for plan years beginning after December 31, 2013. Except as otherwise specified in this chapter, the chapter

applies to for small and large employers. Sections 20:06:40:75 to 20:06:40:88 not apply to grandfathered health plans.

Sections 20:06:40:01, 20:06:40:03, 20:06:40:06, 20:06:40:08, 20:06:40:09, 20:06:40:10, 20:06:40:11, 20:06:40:12, and 20:06:40:14 are repealed effective January 1, 2014.

Sections 20:06:40:01.01 and 20:06:40:03.01 are effective January 1, 2014.

Section 20:06:40:04 only applies to grandfathered plans.

Source:

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79, 58-18-80.

DEPARTMENT OF ~~REVENUE~~ LABOR AND REGULATION

DIVISION OF INSURANCE

EXAMPLE OF CERTIFICATE OF PRIOR GROUP HEALTH PLAN COVERAGE

Chapter 20:06:40

APPENDIX A

SEE: § 20:06:40:03

Source: 24 SDR 35, effective September 29, 1997.

CERTIFICATE OF PRIOR GROUP HEALTH PLAN COVERAGE

IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6 month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____.

2. Name of group health plan: _____.

3. Name of participant: _____.

4. Identification number of participant: _____.

5. Name of any dependents to whom this certificate applies: _____
   _____

6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
   _____
   _____

7. For further information, call: _____.

8. If the individual(s) identified in line 3 and 5 has at least 18 months of credible coverage (disregarding periods of coverage before a 63-day break), check here ___ and skip lines 9 and 10.

9. Date waiting period of affiliation period (if any) began: _____.

10. Date coverage began: _____.

11. Date coverage ended: _____ (or check if coverage is continuing as of the date of this certificate ___).

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

DEPARTMENT OF ~~REVENUE~~ LABOR AND REGULATION

DIVISION OF INSURANCE

NOTICE OF RESEARCH EXCEPTION

Chapter 20:06:40

APPENDIX B

SEE: § 20:06:40:34

Source: 37 SDR 47, effective September 20, 2010.

Notice of Research Exception

PART I: Entity Classification and Identification

1. Date of submission: _____

2. Specify whether the entity claiming the research exception is:

(A) ☐ A group health plan (plan); or

(B) ☐ A health insurance issuer (issuer).

3. If the entity is a plan (as designated in Box 2A), is the plan:

(A) ☐ A plan subject to Part 7 of Title I of ERISA;

(B) ☐ A church plan; or

(C) ☐ A nonfederal governmental plan.

4. If the entity is an issuer (as designated in Box 2B), is the issuer claiming the exception in connection with the provision of:

(A) ☐ Group health insurance coverage only;

(B) ☐ Individual health insurance coverage only; or

(C) ☐ Both group and individual health insurance coverage.

5a. Name and address of the entity claiming the exception:

_____

_____

_____

5b. Telephone number of entity claiming the exception:

_____

5c. Employer Identification Number (EIN) of the entity claiming the exception:

_____

5d. If the entity is a plan (as designated in Box 2A), specify plan number:

_____

PART II: Research Project Information

6. Title of the research project:

_____

7. Name of the principal investigator:

_____

8. Research project number (if available):

_____

PART III: Attestation of Compliance with the Requirements of the Research Exception

With respect to the research project described in Part II, I attest that the following is true:

> *(i) The research complies with 45 CFR part 46 or equivalent federal regulations and applicable state or local law or regulations for the protection of human subjects in research; (ii) each request of a participant or beneficiary (or in the case of a minor child, the legal guardian of such beneficiary) to undergo genetic testing as part of the research will be made in writing and clearly indicate that compliance with the request is voluntary and that noncompliance will have no effect on eligibility for benefits or premium or contribution amounts; and (iii) no genetic information collected or acquired through this research will be used for underwriting purposes.*

Under penalty of perjury, I declare that I have examined this notice, including any accompanying attachments, and to the best of my knowledge and belief, it is true and correct. Under penalty of perjury, I also declare that this notice is complete.

Signature: _____ Date: _____

Type or print name, address, and telephone number:

_____
_____
_____
___

HIPAA RULES -- SMALL EMPLOYER

Section

20:06:41:01 ~~Guaranteed issue~~. Repealed January 1, 2014.

20:06:41:02 ~~Disclosure requirements~~. Repealed January 1, 2014.

20:06:41:03 ~~Guaranteed issue -- Criteria for meeting the exception for issuing coverage to high-risk small employers~~. Repealed January 1, 2014.

20:06:41:04 ~~Guaranteed issue -- Premiums counted toward 2 percent threshold~~. Repealed January 1, 2014.

20:06:41:05 ~~Guaranteed issue -- Formula for calculating percentage of premiums attributable to high-risk small employers~~. Repealed January 1, 2014.

20:06:41:06 ~~Guaranteed issue -- High-risk small employers~~. Repealed January 1, 2014.

20:06:41:07 ~~Guaranteed issue -- Report of meeting 2 percent threshold.~~ Repealed January 1, 2014.

20:06:41:08 ~~Guaranteed issue -- Application for determination of disproportionate share~~. Repealed January 1, 2014.

20:06:41:09 ~~Guaranteed issue -- Filing of application~~. Repealed January 1, 2014.

20:06:41:10 ~~Guaranteed issue -- Director's determination~~. Repealed January 1, 2014.

20:06:41:11 Effective dates.

20:06:41:11. Effective dates. Sections § 20:06:41:01 to 20:06:41:11, inclusive, are repealed effective January 1, 2014.

Source:

General Authority: SDCL 58-18B-20.

Law Implemented: SDCL 58-18B-20.

CHAPTER 20:06:55

~~PATIENT PROTECTION AND AFFORDABLE CARE ACT~~

MARKET REGULATIONS

Section

20:06:55:11 Applicability.

20:06:55:12 Choice of primary care providers.

20:06:55:13 Emergency services.

20:06:55:14 Rescissions.

20:06:55:15 Group plans -- Lifetime limits.

20:06:55:16 Group plans -- Annual limits.

20:06:55:17 Group plans -- Eligibility.

20:06:55:18 Group plans -- Notices and enrollment.

20:06:55:19 Group plans -- Special enrollment.

20:06:55:20 Group plans -- Applicability.

20:06:55:21 Individual plans -- Lifetime limits.

20:06:55:22 Individual plans -- Annual limits.

20:06:55:23 Reinstatement of coverage.

20:06:55:24 Individual plans -- Applicability.

20:06:55:25 Individual plans -- No preexisting condition for a person under the age of 19 -- Open enrollment.

20:06:55:26 Group plans -- No preexisting condition for a person under the age of 19.

20:06:55:27 Excepted benefits -- Defined.

20:06:55:28 Disproportionate share reporting.Repealed January 1, 2014.

20:06:55:29 Disproportionate share based on loss ratio. Repealed January 1, 2014.

20:06:55:30 Disproportionate share based upon covered lives. Repealed January 1, 2014.

20:06:55:31 Length of disproportionate share approval. Repealed January 1, 2014.

20:06:55:32 Definitions.

20:06:55:33 Certifying qualified health plans.

20:06:55:34 Issuer standards and certification criteria.

20:06:55:35 Qualified health plan defined.

20:06:55:36 Exchange network adequacy standards.

20:06:55:37 Network adequacy standards.

20:06:55:38 Essential community providers defined.

20:06:55:39 Essential community providers.

20:06:55:40 Payment of federally-qualified health centers.

20:06:55:41 Treatment of direct primary care medical homes.

20:06:55:42 Recertification of qualified health plans.

20:06:55:43 Decertification of qualified health plan.

20:06:55:44 Non-renewal and decertification of qualified health plans.

20:06:55:45 Rates.

20:06:55:46 Health plan applications and notices.

20:06:55:47 Accreditation of qualified health plan issuers.

20:06:55:48 Initial open enrollment period.

20:06:55:49 Annual open enrollment period.

20:06:55:50 Changing qualified health plans.

20:06:55:50.01. Loss of Coverage.

20:06:55:51 Compensation.

20:06:55:52 Plan offerings in the exchange.

20:06:55:53 Applicability and effective dates.

Appendix A Model Choice of Health Care Professional Notice Language.

20:06:55:16. Group plans -- Annual limits. With respect to plan years beginning prior to January 1, 2014, a group health plan may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits if the limit is no less than the following:

(1) For a plan year beginning after September 22, 2010, but before September 23, 2011, $750,000;

(2) For a plan year beginning after September 22, 2011, but before September 23, 2012, $1,250,000;

(3) For plan years beginning after September 22, 2012, but before January 1, 2014, $2,000,000.

In determining whether an individual has received benefits that meet or exceed the allowable annual limits as required by this section the plan or issuer ~~must~~ may only take into account ~~only~~ essential health benefits.

For plan years beginning after December 31, 2013, no annual dollar limit is permitted for essential health benefits.

Source: 37 SDR 63, effective September 23, 2010; 37 SDR 111, effective December 7, 2010.

General Authority: SDCL 58-18-79.

Law Implemented: SDCL 58-18-79.

20:06:55:22. Individual plans -- Annual limits. With respect to policy years beginning prior to January 1, 2014, a health plan may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits provided the limit is no less than the following:

(1) For a plan year beginning after September 22, 2010, but before September 23, 2011, $750,000;

(2) For a plan year beginning after September 22, 2011, but before September 23, 2012, $1,250,000;

(3) For plan years beginning after September 22, 2012, but before January 1, 2014, $2,000,000.

In determining whether an individual has received benefits that meet or exceed the allowable annual limits as required by this section the plan or issuer ~~must~~ may only take into account ~~only~~ essential health benefits.

For plan years beginning after December 31, 2013, no annual dollar limit is permitted for essential health benefits.

Source: 37 SDR 63, effective September 23, 2010; 37 SDR 111, effective December 7, 2010.

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:55:25. Individual plans -- No preexisting condition for a person under the age of 19 -- Open enrollment. ~~No health policy, certificate, or plan may limit or exclude coverage based upon a preexisting condition for a person under the age of 19. For policies issued after March 23, 2010, but before September 23, 2010, any remaining preexisting condition waiting period must be removed beginning on the first day of the policy year following September 22, 2010. For individual policies issued after September 22, 2010, no preexisting waiting period for persons under the age of 19 may be applied. Each individual health carrier must provide for an open enrollment period of 45 days each year beginning July 1, 2011, and each July first thereafter, during which any persons under the age of 19 who apply are qualified for coverage. During the open enrollment period, no individual health carrier may deny or unreasonably delay the issuance of a policy, refuse to issue a policy, or issue a policy with any health condition exclusionary rider or endorsement on an applicant or insured that is under the age of 19 except upon the failure to pay the applicable premium. Any substantially completed application received within 15 days of the signature date during the open enrollment period must be treated as an application received during open enrollment pursuant to this section. A substantially completed application received by an individual health carrier during open enrollment shall be considered under provisions in place during the open enrollment period not only for the carrier to which the application was submitted but also for any subsequent carriers from which the individual is seeking coverage during open enrollment as long as the application is submitted and received by any subsequent carrier within 15 days after the individual seeking coverage is notified they are unable to obtain coverage from their individual health carrier that received the~~

~~application during the open enrollment period. A health carrier may decline coverage to applicants for non-dependent coverage under the age of 19 during the open enrollment period if applicant has coverage under a group health plan or other creditable coverage. For purposes of this section other creditable coverage does not include a high risk pool, an individual health benefit plan with exclusionary riders, Medicaid, CHIP, or a plan providing less than basic benefits. An individual health carrier may not deny coverage to an applicant under the age of 19 during the open enrollment period based solely upon that applicant being a current insured on an individual health policy or being previously insured with that same individual health carrier. An individual health carrier may deny the issuance of coverage to an applicant under the age of 19 if that applicant has cancelled or lapsed creditable coverage within 90 days prior to the date of application. The effective dates for policies issued to applicants under age 19 outside the open enrollment period may be based upon the individual health carrier's normal business practices. The effective date of a policy issued pursuant to the open enrollment period must be based on one of the following methods:~~

~~(1) The date of application;~~

~~(2) The first day of the month following the receipt of application; or~~

~~(3) A date mutually agreed upon by the applicant and the health carrier.~~

~~Each health carrier must provide prior written notice to each of its policyholders annually after March 31, but not later than July 1, of the open enrollment rights for persons under the age of 19 and provide information as to how an eligible person may apply for coverage with that health carrier during the open enrollment period. In addition, each health carrier must post on its website, not later than July 15 for the year 2011, and not later than May 1 for each year thereafter, information about open enrollment rights of a person under the age of 19 and how an eligible person may apply for coverage during the open enrollment period. The information must remain on the health carrier's website until August 15 of the applicable year, and shall be posted in a location that is readily accessible to the general public. A web posting will be considered readily accessible if there is a prominently displayed link either on the health carrier's main page or on a page normally utilized by persons seeking coverage in this state. Nothing in this section prohibits an insurer from issuing a policy with a health condition rider, endorsement, or declining coverage for an application that is received from a person under the age of 19 outside of the open enrollment period. Nothing in this section requires a health carrier to remove a rider or endorsement that was attached to or made part of a policy either in compliance with this section or attached or made part of a policy issued prior to the effective date of this section. Except as provided by § 20:06:39:08, a health carrier is not required to offer a child only policy. Applications received during open enrollment must be considered on a first come first serve basis for purposes of §§ 20:06:55:28 to 20:06:55:30, inclusive, and shall be subject to the provisions of § 20:06:39:09.~~

~~Except for those coverages that are excepted benefits pursuant to SDCL subdivision 58-17-69(13), this section applies to any plan of individual health insurance coverage and to any health benefit plan subject to the provisions of SDCL 58-17-66 to 58-17-87, inclusive.~~Repealed January 1, 2014.

Source: 37 SDR 63, effective September 23, 2010; 37 SDR 111, effective December 7, 2010; 37 SDR 215, effective May 31, 2011; 38 SDR 40, effective September 20, 2011.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-84, 58-17-87, 58-17-97.~~

20:06:55:25.01 Individual plans -- No preexisting condition. No health policy, certificate, or plan may limit or exclude coverage based upon a preexisting condition for a person. For policies issued after March 23, 2010, but before September 23, 2010, any remaining preexisting condition waiting period must be removed beginning on the first day of the policy year following September 22, 2010. For individual policies issued after September 22, 2010, no preexisting waiting period for persons under the age of 19 may be applied. For persons who are age 19 or over no preexisting condition may apply after December 31, 2013. This section does not apply to grandfathered plans.

If a health insurance issuer offers health insurance coverage in any level of coverage other than excepted benefits, the issuer shall also offer such coverage in that level as a plan in

which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

This section does not apply to a plan that is stand-alone dental.

Except for those coverages that are excepted benefits pursuant to SDCL subdivision 58-17-69(13), this section applies to any plan of individual health insurance coverage and to any health benefit plan subject to the provisions of SDCL 58-17-66 to 58-17-87, inclusive.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-84, 58-17-87, 58-17-97.

20:06:55:28. Disproportionate share reporting. ~~All health carriers marketing individual health policies, other than excepted benefits, to those under the age of 19 must report, in the format prescribed by the director, the required information relative to those under the age of 19. The report for the first quarter of calendar year 2011 must be filed no later than July 1, 2011. Subsequent quarterly reports must be filed no later than March 1, June 1, September 1, and December 1 of each year.~~

~~An individual health carrier may qualify for a determination of disproportionate share based upon either §§ 20:06:55:29 or 20:06:55:30. Any individual health carrier wishing to have a determination of disproportionate share must file a request with the director who shall promptly determine the eligibility of that individual health carrier pursuant to §§ 20:06:55:28 to 20:06:55:31, inclusive.~~ Repealed January 1, 2014.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-84, 58-17-87, 58-17-97.~~

20:06:55:29. Disproportionate share based on loss ratio. ~~The formula for determining disproportionate share based upon loss ratio shall be determined using the percentage derived by dividing the average loss ratio of all carriers reporting pursuant to § 20:06:55:28 on that portion of individual health policies that is guaranteed issue by the overall loss ratio of all individual health policies. Any carrier whose percentage of loss ratio attributable to guaranteed issue business is fifteen percent or more above the average percentage of all carriers, has met the requirements for disproportionate share for purposes of § 20:06:39:08.~~ Repealed January 1, 2014.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-84, 58-17-87, 58-17-97.~~

20:06:55:30. Disproportionate share based upon earned premium. ~~If a carrier has issued individual health coverage, other than excepted benefits, to persons who are under the age of 19 on a guaranteed issue basis and those persons would not otherwise qualify for coverage~~

~~because of medical underwriting the earned premium on those persons and any earned premium that would be collected if the policy stays in force for the balance of the calendar year is the numerator. The denominator is the total earned premium in the prior calendar year on all individual health policies for that individual health carrier. If the percentage derived from dividing the denominator into the numerator exceeds 1%, then the carrier has met the requirements for disproportionate share for purposes of § 20:06:39:08. Policies issued with exclusionary riders may not be considered in the calculation of disproportionate share for purposes of this section.~~ Repealed January 1, 2014.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-84, 58-17-87, 58-17-97.~~

20:06:55:31. Length of disproportionate share approval. ~~Upon approval of an individual health carrier's application for a determination of disproportionate share, that determination will remain in effect until such time as that health carrier no longer has a disproportionate share of guaranteed issue coverage based upon either §§ 20:06:55:29 or 20:06:55:30. Once a health carrier no longer meets the disproportionate share threshold, that carrier must notify the director. For health carriers who qualified for disproportionate share pursuant to § 20:06:55:29, the notice to the director must be within 45 days of the date that individual health carrier no longer meets the criteria for disproportionate share. For health carriers who qualified for disproportionate share pursuant to § 20:06:55:30, the notice to the director must be within 30 days of the date that individual health carrier no longer meets the~~

~~criteria for disproportionate share. Nothing in this section requires a carrier to assess whether it no longer meets the criteria for disproportionate share more frequently than monthly.~~ Repealed January 1, 2014.

Source: 37 SDR 215, effective May 31, 2011.

~~**General Authority:** SDCL 58-17-87.~~

~~**Law Implemented:** SDCL 58-17-84, 58-17-87, 58-17-97~~

20:06:55:32. Definitions.

(1) "Exchange," individual and SHOP Exchange;

(2) "HHS," United States Department of Health and Human Services;

(3) "Health insurance issuer," any person that provides health insurance in this state including an insurance company, a prepaid hospital, or similar plan, a health maintenance organization, a multiple employer welfare arrangement, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. A health insurance issuer does not include a person providing only excepted benefits;

(4) "Individual Exchange, " an Exchange as provided for by section 1311 of PPACA to provide coverage to individuals;

(5) "PPACA," means the Patient Protection and Affordable Care Act (P.L. 111-148, 2010), as amended by the Health Care and Education Reconciliation Act (P.L. 111-152, 2010);

(6) "SHOP Exchange," An Exchange provided for by section 1311 of PPACA to provide coverage to small employers.

20:06:55:33. Certifying qualified health plans. A health insurance issuer selling plans in an Exchange may offer only health plans which have in effect a certification issued by the director as a qualified health plan, unless specifically provided for otherwise.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:34. Issuer standards and certification criteria. In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the director to demonstrate that each health plan it offers in an Exchange is a qualified health plan. The director may certify a health plan as a qualified health plan if the requirements of 20:06:55:35 are met or the director determines that making the health plan available is in the interest of the qualified individuals and qualified employers. The director may not exclude a health plan on the following basis:

(1) Such plan is a fee-for-service plan;

(2) Through the imposition of premium price controls; or

(3) That the health plan provides treatments necessary to prevent patients' deaths in circumstances determined to be inappropriate or too costly.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:35. Qualified health plan defined. A qualified health plan is a health plan that has been certified by the division that such plan meets the following criteria:

(1) Provides the essential health benefits package described in § 20:06:56:03;

(2) Meets actuarial value standards as described in § 20:06:56:11;

(3) Is licensed by and in good standing with the director;

(4) Includes a network that is compliant with SDCL 58-17F, § 20:06:55:36, and § 20:06:55:37 ;

(5) Complies with marketing laws;

(6) Is accredited based on local performance by an accrediting entity recognized by HHS as described in §20:06:56:12;

(7) The rates comply with §§ 20:06:22 and 20:06:55:45;

(8) Is non-discrimination compliant with § 20:06:45;

(9) Includes plan variations for individuals eligible for cost-sharing reductions and for American Indian and Alaska Native populations;

(10) Complies with the benefit design standards, as defined in § 20:06:56:08;

(11) Implements and reports on a quality improvement strategy or strategies to disclose and report information on health care quality and outcomes;

(12) Complies with the standards related to the risk adjustment program under 45 CFR part 153 (March 12, 2012).

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:36. Exchange network adequacy standards. A qualified health plan issuer must ensure that the provider network of each qualified health plan meets the standards specified in SDCL Chapter 58-17F. A qualified health plan in an Exchange may contract with any essential community provider. The service area of a qualified health plan is subject to the approval of the director and must cover a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the director. The service area of a qualified health plan must be established without regard to racial, ethnic, language, health status-related factors or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:37. Network adequacy standards. A qualified health plan issuer must ensure that the provider network of each of its qualified health plan meets the following standards:

(1) Includes essential community providers in accordance with §§ 20:06:55:38 and 20:06:55:39 ;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services are accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of SDCL Chapter 58-17F.

A qualified health plan issuer must make its provider directory for a qualified health plan available for publication online to potential enrollees in hard copy upon request. In the provider directory, a qualified health plan issuer must identify providers that are not accepting new patients.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:38. Essential community providers defined. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, unless the provider lost its status as a result of a violation of Federal law:

(1) Health care providers defined in section 340B(a)(4) of the Public Health Service Act (Pub. L. 102-585), as amended by PPACA, Health Care and Education Reconciliation Act (Pub. L. 111-152), and Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309); and

(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Public Health Service Act as set forth by section 221 of Pub. L. 111-8 (March 11, 2009).

Nothing in this section shall be construed to require a qualified health plan issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:39. Essential community providers. A qualified health plan issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the qualified health plan's service area.

A qualified health plan issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may, with approval from the director, as an alternative to the standard set forth above comply as follows:

A qualified health plan issuer must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the qualified health plans service area.

Nothing in this section shall be construed to require any qualified health plan to provide coverage for any specific medical procedure provided by the essential community provider.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:40. Payment of federally-qualified health centers. If an item or service covered by a qualified health plan is provided by a federally-qualified health center to an enrollee of a qualified health plan, the qualified health plan issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would be required to be paid to the center under section 1902(bb) of PPACA for such item or service. Nothing in this section would preclude a qualified health plan issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would be paid to the center under section 1902(bb) of PPACA, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:41. Treatment of direct primary care medical homes. A qualified health plan issuer may provide coverage through a direct primary care medical home that the meets criteria established by HHS, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the direct primary care medical home are coordinated with the qualified health plan issuer.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:42. Recertification of qualified health plans. Each qualified health plan offered in an Exchange must obtain annual recertification from the director in accordance with the criteria as outlined in § 20:06:55:35 by September 15th of each year. Upon determining the recertification status of a qualified health plan the director shall notify qualified health plan issuers.

If a qualified health plan issuer elects not to seek recertification with an Exchange for its qualified health plan, the qualified health plan issuer must provide written notice of the election to each enrollee.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:43. Decertification of qualified health plan. If an issuer offering a qualified health plan is no longer in compliance with the general certification criteria as outlined in § 20:06:55:35 the issuer may not offer coverage through an Exchange.

If a qualified health plan is decertified or otherwise not approved to offer coverage through an Exchange the qualified health plan issuer must terminate coverage for enrollees only after:

(1) The plan provides notification as described in § 20:06:55:46; and

(2) Enrollees have an opportunity to enroll in other coverage.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:44. Non-renewal and decertification of qualified health plans. If a qualified health plan issuer elects not to seek recertification with the director, the qualified health plan issuer must:

(1) Notify the director of its decision prior to the beginning of the recertification process;

(2) Fulfill its obligation to cover benefits for each enrollee through the end of the plan or benefit year;

(3) Fulfill data reporting obligations from the last plan or benefit year of the certification;

(4) Provide notice to enrollee in writing; and

(5) Terminate coverage for enrollees in the qualified health plan once enrollees have an opportunity to enroll in other coverage.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:45. Rates. A qualified health plan issuer must set rates for an entire benefit year, or for the SHOP Exchange, plan year. An issuer must submit rate and benefit information to the director. A qualified health plan issuer must submit to the director a justification for a rate increase prior to the implementation of the increase. A qualified health plan issuer must

prominently post the justification for a rate increase on its website. A qualified health plan issuer may vary premiums by the geographic rating area described in § 20:06:22:29.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:46. Health plan applications and notices. A qualified health plan issuer must provide all applications and notices to enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities including accessible web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act, Pub. L. No. 101-336 (1990), as amended, and section 504 of the Rehabilitation Act, Pub. L. No. 93-112 (1973), as amended. Individuals who are limited English proficient through the provision of language services at no cost to the individual.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:47. Accreditation of qualified health plan issuers. A qualified health plan issuer must be accredited on the basis of local performance of a qualified health plan in accordance with § 20:06:56:12.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:48. Initial open enrollment period. A health insurance issuer must provide for an initial open enrollment period in the individual market Exchange beginning October 1, 2013 and extending through March 31, 2014. Effective coverage dates for initial open enrollment period must be as follows:

(1) For a person enrolling on or before December 15, 2013, the issuer must make the coverage effective January 1, 2014;

(2) For a person enrolling between the first and fifteenth day of any month between January 2014 and March 2014, the issuer must make a coverage effective on the first day of the following month; and

(3) For a person enrolling between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the issuer must make a coverage effective on the first day of the second following month.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:49. Annual open enrollment period. For benefit years after December 31, 2014, inside the Exchange all issuers must provide for an annual open enrollment period for the

individual market inside the Exchange that begins October 15 and extends through December 7 of the preceding calendar year.

Coverage must be effective as of the first day of the following benefit year for a qualified individual who selects a qualified health plan during the annual open enrollment period.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:50. Changing qualified health plans. A health insurance issuer must allow a qualified individual or enrollee in an Exchange to enroll in or change from one qualified health plan to another as a result of the following triggering events:

(1) A qualified individual or dependent loses minimum essential coverage except for in the case of nonpayment of premium;

(2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;

(4) A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the health insurance issuer. In such cases, the health insurance issuer may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(5) An enrollee adequately demonstrates to the director that the qualified health plan in which the individual is enrolled substantially violated a material provision of its contract in relation to the individual;

(6) A qualified individual or enrollee gains access to new qualified health plans as a result of a permanent move;

(7) A qualified individual or enrollee meets other exceptional circumstances as the director may provide; and

(8) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, Pub. L. No. 94-437 (1976), as amended, may enroll in a qualified health plan or change from one qualified health plan to another one time per month and is not subject to any qualifying event.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:50.01. Loss of Coverage. Loss of coverage does not include termination or loss due to:

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

(2) Situations allowing for a rescission.

If the triggering event is loss of qualified health plan a qualified individual or enrollee may only move to a different plan at the same level of coverage as the enrollees current plan.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:51. Compensation. A qualified health plan issuer must pay the same broker compensation for a qualified health plan offered through an Exchange that the qualified health plan issuer pays for a similar health plan offered outside an Exchange.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:52. Plan offerings in the exchange. A qualified health plan issuer must offer at least one qualified health plan in the silver level and at least one plan in the gold level to participate in an Exchange.

Section 20:06:55:25, 20:06:55:28, 20:06:55:29, 20:06:55:30, 20:06:55:31 are repealed effective January 1, 2014.

Section 20:06:55:33 to 20:06:55:52, inclusive, are effective January 1, 2014.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:55:53. Applicability and effective dates. The open enrollment provisions of §§ 20:06:55:48 and 20:06:55:49 do not apply to any coverage issued to an employer that covers at least two individuals.

Sections §§ 20:06:55:25, 20:06:55:28, 20:06:55:29, 20:06:55:30, and 20:06:55:31 are repealed effective January 1, 2014.

Sections §§ 20:06:55:33 to 20:06:55:52, inclusive, are effective January 1, 2014.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

DEPARTMENT OF ~~REVENUE~~ LABOR AND REGULATION

DIVISION OF INSURANCE

MODEL CHOICE OF HEALTH CARE PROFESSIONAL NOTICE LANGUAGE

Chapter 20:06:55

APPENDIX A

SEE § 20:06:55:12

Source: 37 SDR 111, effective December 7, 2010.

Appendix A - Model Choice of Health Care Professional Notice Language

- For health carries that require or allow for the designation of primary care health care professionals, beneficiaries or enrollees, insert:

  [Name of health ~~carrier~~ health insurance issuer**] generally [requires/allows] the designation of a primary care health care professional. You have the right to designate any primary care health care professional who participates in our network and who is available to accept you or your family members.** [If the health ~~carrier~~ health insurance issuer designates a primary care health care professional automatically, insert: **Until you make this designation, [name of health** ~~carrier~~ health insurance issuer**] designates one for you.] For information on how to select a primary care health care professional, and for a list of participating primary care health care professionals, contact the [health** ~~carrier~~ health insurance issuer**] at [insert contact information].**

- For health ~~carrier~~ health insurance issuer that require or allow for the designation of a primary care health care professional for a child, add:

  For children, you may designate a pediatrician as the primary care health care professional.

- For ~~carrier~~ health insurance issuers that provide coverage for obstetric or gynecological care and require the designation by a participant, beneficiary or enrollee of a primary care health care professional, add:

  You do not need prior authorization from [name of ~~health~~ ~~carrier~~ health insurance issuer**] or from any other person, including a primary care health care professional, in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [health** ~~carrier~~ insurance issuer**] at [insert contact information].**

CHAPTER 20:06:56

MINIMUM BENEFIT STANDARDS

Section

20:06:56:01 Definitions.

(1) "Actuarial value," a measure of the percentage of expected health care costs a health plan will cover for a standard population and can be considered a general summary measure of health plan generosity;

(2) "Actuarial value calculator," used to determine the actuarial value of applicable plans. It is developed using a set of claims data weighted to reflect the standard population projected to enroll in the individual and small group markets for the identified year of enrollment;

(3) "Base-benchmark plan," the plan that is selected by the state from the options described in 45 CFR §156.100(a), or a default benchmark plan, as described in 45 CFR §156.100(c), prior to any adjustments made pursuant to the benchmark standards described in 45 CFR §156.110;

(4) "De minimis variation," is the allowable variation in the actuarial value of a health plan that does not result in a material difference in the true dollar value of the health plan is +/- 2 percentage points;

(5) "Essential health benefits benchmark plan," is the standardized set of essential health benefits that must be met by a qualified health plan;

(6) "HHS," United States Department of Health and Human Services;

(7) "Premium adjustment percentage," The percentage by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance.

Source:

General Authority: SDCL 58-17-87.

Law Implemented: SDCL 58-17-87.

20:06:56:02. Covering essential health benefits. Health insurance coverage in the individual and small group markets must cover essential health benefits for plan years beginning after December 31, 2013. Sections 20:06:56:01 through 20:06:56:10 apply to those plans offered inside an Exchange and those offered outside an Exchange.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:03. Essential health benefits . The essential health benefits package consists of the following categories of benefits:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorder services, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management, and;

(10) Pediatric services, including oral and vision care.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:04. Substantially equal benefits. Plans must provide for benefits that are substantially equal to the essential health benefits-benchmark plan including:

(1) Covered benefits listed in § 20:06:56:02;

(2) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(3) Prescription drug benefits described in § 20:06:56:07.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:05. Substituted benefits. A plan may substitute benefits from the essential health benefits benchmark benefit plan if it meets the following conditions:

(1) The substitute benefit is actuarial equivalent to the essential health benefit;

(2) The substitute benefit is made only within the same essential benefit category; and

(3) The benefit is not a prescription drug benefit;

The plan must submit evidence of the actuarial equivalence of the substituted benefit to the director. The certification must be conducted by a member of the American Academy of Actuaries, be based on an analysis performed in accordance with generally accepted actuarial principles and methodologies, and use a standardized plan population. Actuarial equivalence of benefits is determined regardless of cost-sharing.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:06. Pediatric dental. A stand-alone dental plan covering pediatric dental may be used to cover the pediatric dental component of essential health benefits required by § 20:06:56:02. A stand-alone dental plan covering the pediatric dental category under § 20:06:56:02 must demonstrate to the director that it has a reasonable annual limitation on cost-sharing. An issuer must demonstrate that the stand-alone dental plan offers the pediatric dental essential health benefit within a de minimis variation of +/- 2 percentage points of the level of coverage in at subsections (1) and (2) at either:

(1) A low level of coverage with an AV of 70 percent; or

(2) A high level of coverage with an AV of 85 percent; and

The coverage levels described above must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles and provided to the division.

A health benefit plan offered in the small group or individual market, which does not include minimum essential pediatric dental benefits, offers the minimum essential health benefits required under law only, if:

(1) There is at least one dental benefits carrier offering the federally-required minimum pediatric dental benefits in the state,

(2) The health benefit plan makes prominent disclosure at the time that it offers the plan, in a form approved by the director, that the health benefit plan does not provide the essential pediatric dental benefits; and

(3) That the dental benefits carriers providing the federally required minimum pediatric dental benefits and other dental benefits are licensed to offer dental benefits in the state.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:07. Prohibited benefits. An issuer of a plan offering essential health benefits may not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or not medically necessary orthodontia as essential health benefits.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:08. Prescription drug benefits. A health plan does not provide essential health benefits unless it covers at least the greater of;

(1) One drug in every United States Pharmacopeia (USP) category and class; or

(2) The same number of prescription drugs in each category and class as the essential health benefits benchmark.

The plan is required to submit its drug list to the director. A health plan does not fail to provide essential health benefits for prescription drug solely because it does not offer drugs for services prohibited under SDCL 58-17-147 A health plan providing essential health benefits as defined in § 20:06:56:03 must have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan.

Reference: United States Pharmacopeia (USP)

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:09. Prohibited discriminatory benefit design. A health insurance issuer does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted

disability, degree of medical dependency, quality of life, or other health conditions. An issuer must not employ in discriminatory marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in nongrandfathered health plan s.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:10. Actuarial value calculator. A health insurance issuer may use the actuarial value calculator to determine the actuarial value of a health plan made available by Health and Human Services. Actuarial Value within a de minimis variation determines whether a health plan offers a bronze, silver, gold, or platinum level of coverage.

If a health plan's design is not compatible with the actuarial value calculator, the issuer must meet the following:

(1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in subdivisions (2) and (3) of this section:

(2) Calculate the plan's actuarial value by estimating a fit of its plan design into the parameters of the actuarial value calculator and having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

(3) Use the actuarial value calculator to determine the actuarial value for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the actuarial value identified by the calculator, for plan design features that deviate substantially from the parameters of the actuarial value calculator.

The calculation methods described in subdivisions (2) and (3) of this section may include only in-network cost-sharing, including multi-tier networks.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:11. Levels of coverage. The levels of coverage are calculated as follows:

(1) A bronze health plan is a health plan that has an actuarial value of 60 percent;

(2) A silver health plan is a health plan that has an actuarial value of 70 percent;

(3) A gold health plan is a health plan that has an actuarial value of 80 percent; and

(4) A platinum health plan is a health plan that has as an actuarial value of 90 percent.

Actuarial value within a de minimis variation determines whether a health plan offers a bronze, silver, gold, or platinum level of coverage.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:12. Accreditation. A qualified health plan must be accredited in the following categories by an accrediting entity recognized by HHS prior to certification:

(1) Clinical quality measures, such as the healthcare effectiveness data and Information Set;

(2) Patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey;

(3) Consumer access;

(4) Utilization management;

(5) Quality assurance;

(6) Provider credentialing;

(7) Complaints and appeals;

(8) Network adequacy and access; and

(9) Patient information programs.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:13. Accreditation timeline. During certification for an issuer's initial year of qualified health plan certification a qualified health plan issuer without existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity for

the same state in which the issuer is applying to offer coverage must have scheduled or plan to schedule a review of qualified health plan policies and procedures of the applying qualified health plan issuer with a recognized accrediting entity.

Prior to a qualified health plan issuer's second year and third year of qualified health plan certification, a qualified health plan issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products, or a qualified health plan issuer must have commercial or Medicaid health plan accreditation granted by a recognized accrediting entity for the same state in which the issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the qualified health plan.

Prior to the qualified health plan issuer's fourth year of qualified health plan certification and in every subsequent year of certification, a qualified health plan issuer must be accredited in accordance with § 20:06:56:12

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:14. Provider credentialing. A health insurance issuer's selection standards for participating providers shall be developed for primary care professionals and each health care

professional specialty. The standards shall be used in determining the selection of health care professionals by the health insurance issuer, its intermediaries, and any provider networks with which it contracts. The standards shall meet the requirements of the National Association of Insurance Commissioners Health Care Professional Credentialing Verification Model Act.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

Reference: National Association of Insurance Commissioners Health Care Professional Credentialing Verification Model Act

20:06:56:15. Annual limitation on cost sharing. For a plan year beginning in calendar year 2014, cost sharing may not exceed the following:

(1) For self-only coverage--the annual dollar limit as described in 26 U.S.C. § 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that that is in effect for 2014; or

(2) For other than self-only coverage--the annual dollar limit in 26 U.S.C. § 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986 as amended, for non-self-only coverage that is in effect for 2014.

For a plan year beginning in a calendar year after December 31, 2014, cost sharing may not exceed the following:

(1) For self-only coverage--the dollar limit for calendar year 2014 increased by an

amount equal to the product of that amount and the premium adjustment percentage;

(2) For other than self-only coverage--twice the dollar limit for self-only coverage described in subsection 1.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:16. Annual limitation on deductibles for plans in the small group market. For a plan year beginning in calendar year 2014, the annual deductible for a health plan in the small group market may not exceed the following:

(1) For self-only coverage--$2,000; or

(2) For coverage other than self-only--$4,000.

For a plan year beginning in a calendar year after 2014, the annual deductible for a health plan in the small group market may not exceed the following:

(1) For self-only coverage--the annual limitation on deductibles for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage; and

(2) For other than self-only coverage--twice the annual deductible limit for self-only coverage.

A health plan's annual deductible may exceed the annual deductible limit if that plan may not reasonably reach the actuarial value of a given level of coverage without exceeding the annual deductible limit.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:17. Network plan cost sharing. In the case of a plan using a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network shall not count towards the annual limitation on cost-sharing or the annual limitation on deductibles.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:18. Increase annual dollar limits in multiples of 50. For a plan year beginning in a calendar year after December 31, 2014, any increase in the annual dollar limits that do not result in a multiple of 50 dollars must be rounded to the next lowest multiple of 50 dollars.

Source:

General Authority: SDCL 58-17-87, 58-18-79.

Law Implemented: SDCL 58-17-87, 58-18-79, 58-18-80.

20:06:56:19. Catastrophic plan. A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if

(1) the only individuals who are eligible to enroll in the plan are individuals described in 1302 (e); and

(2) The plan provides except as provided in clause 1302 (e), the essential health benefits determined under section 1302 of the ACA, except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) of section 1302 for the plan year except as provided for in section 2713; and coverage for at least three primary care visits.

An individual is described in this paragraph for any plan year if the individual has not attained the age of 30 before the beginning of the plan year; or has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of section 5000A(e)(1) of such Code relating to individuals without affordable coverage; or section 5000A(e)(5) of such Code relating to individuals with hardships.

If a health insurance issuer offers a health plan described in this section, the issuer may only offer the plan in the individual market.

The cost-sharing incurred under a health plan described in this section with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

In the case of any plan year beginning in a calendar year after December 31, 2014 the limitation under this section shall in the case of self-only coverage, be equal to the dollar amount

under described above for selfonly coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage for the calendar year; and in the case of other coverage, twice the amount in effect. If the amount of any increase is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

20:06:56:20. Applicability. The provisions of § 20:06:56:01 to 20:06:56:19, inclusive, only apply to non-grandfathered plans effective January 1, 2014.